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In the Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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QUESTIONS PRESENTED

1. May health care providers and their patients bypass state remedies and sue under 42 U.S.C. § 1983 to challenge state Medicaid reimbursement decisions when, pursuant to the express directives of the Medicaid Act and federal implementing regulations, the state has established administrative procedures specifically to address those claims?

2. Do the rate reimbursement provisions established by the states as part of their state Medicaid plans give rise to federal rights enforceable under 42 U.S.C. § 1983?

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PETITION FOR WRIT OF CERTIORARI

Petitioners, the Department of Human Resources of the State of Oregon, and Richard C. Ladd, Administrator of the Senior Services Division of the Department of Human Resources, (hereinafter "the state"), respectfully pray that this Court issue a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, No. 85-4049 (November 3, 1986).

OPINIONS BELOW

The opinion of the Ninth Circuit Court of Appeals is reported as *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), and is attached to this petition as Appendix A. The order and judgment of the district court is unreported, and is attached as Appendix B. The magistrate's Findings and Recommendations are also unreported, and are attached as Appendix C. The magistrate relied substantially upon the earlier decision of the District Court of Oregon in *Beecroft v. Atiyeh*, Civil No. 78-1027-BU (1982) which is also unreported and is attached as Appendix D.

JURISDICTION

The opinion of the Ninth Circuit Court of Appeals was dated and filed on November 3, 1986. The judgment sought to be reviewed was entered on the same date. Jurisdiction to review the judgment in this civil case by writ of certiorari is conferred upon this Court by 28 U.S.C. § 1254(1) (1982). This petition for writ of certiorari is filed within the time allowed by order of this Court dated January 20, 1987, which extended the time for filing this petition to March 3, 1987.

STATUTES AND REGULATIONS INVOLVED

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982), provides, in pertinent part:

§ 1396 For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

§ 1396a(a) A State plan for medical assistance must—

. . . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

. . . .

(13) provide—

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality

. . . .

. . . .

(37) provide for claims payment procedures which . . . (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

2. 42 U.S.C. § 1983 (1982) provides in pertinent part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

3. 42 C.F.R. § 431.220(a) provides:

(a) The agency must grant an opportunity for a hearing to:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness; and

(2) Any recipient who requests it because he believes the agency has taken an action erroneously.

4. 42 C.F.R. § 431.241 provides:

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility; and

(b) Agency decisions regarding changes in the type or amount of services.

5. 42 C.F.R. § 431.246 provides:

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

6. 42 C.F.R. § 447.253(c) provides:

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

STATEMENT OF THE CASE

Plaintiff Coos Bay Care Center (hereinafter "CBCC") is an intermediate care facility that provides long-term health care services for the developmentally disabled and the aged. (Findings and Recommendation, Appendix C at App-10). CBCC participates as a health care provider in Oregon's Medicaid program. (*Id.*). The individual plaintiffs are resident patients at CBCC. (Complaint, Appendix E at App-32). Defendant Oregon Department of Human Resources (hereinafter "DHR") is the Oregon state agency responsible for administering the state's Medicaid program. (*Id.*). Defendant Richard C. Ladd is the Administrator of the division of the DHR which directly administers Oregon's Medicaid program. (*Id.*).

Plaintiffs initiated litigation on their own behalf and on the behalf of others similarly situated by filing a complaint under 42 U.S.C. § 1983 seeking damages, injunctive and declaratory relief and certification as a class action. Plaintiffs alleged that defendants failed correctly to classify certain patients (including the individual plaintiffs) as "heavy cost" care patients and, accordingly, failed to reimburse plaintiff CBCC at the special rate applicable under Oregon's Heavy Cost Program for care of those patients. (*Id.* at App-34 - 35.)

Oregon's Heavy Cost Program is narrowly defined by state administrative rules. To be eligible under the rules, patients

must be functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b). The special heavy cost reimbursement rate is expressly identified as an "add-on to the facility's established rate for the clients' level of care." Or. Admin. R. 411-70-030(7)(b).[1]

A facility's established rate for care provided to all patients under Oregon's Medicaid program is determined under the provisions of a separate administrative rule that defines an all-inclusive rate for "all services, supplies and facility equipment required for care." Or. Admin. R. 411-70-085(1)[2] The state has further established the 75th percentile as the rate appropriate to reimburse reasonably an efficiently and economically operated facility. Or. Admin. R. 411-70-440.[3] Accordingly, under Oregon's plan, if a facility's claimed costs for providing the services included in the all-inclusive or established rate fall within the lower 75 percent of costs incurred by all eligible facilities, Oregon reimburses the facility for all of its claimed costs. But if its claimed costs are greater than the costs incurred by those within the lower 75th percentile, Oregon reimburses the facility only at the 75th percentile rate.

The "established rate," thus, is the standard reimbursement rate contained in Oregon's Medicaid plan and approved by the Secretary of the United States Department of Health and Human Services as the rate that adequately will reimburse efficiently operating facilities for services provided to Medicaid patients. The special add-on "heavy cost" reim-

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[1] Or. Admin. R. 411-70-030(1) and (7) are set out in full in Appendix F.

[2] Or. Admin. R. 411-70-085(1) and (2) are set out in full in Appendix G.

[3] Or. Admin. R. 411-70-440 is set out in full in Appendix H.

bursement rate provides complete reimbursement through a special daily rate for services provided to patients who meet the particularized requirements of the Heavy Cost Program.

Plaintiffs' complaint did not claim that Oregon's Medicaid plan itself violates federal law, or that the established rate capped at the 75th percentile level fails to reimburse health care providers at a rate adequate and reasonable to meet the costs which efficiently and economically operated facilities must incur, the standard imposed by 42 U.S.C. § 1396a(a)(13)(A). Rather, plaintiffs' complaint alleged only that certain patients whom plaintiffs contend meet the qualifications of the state's Heavy Cost Program have been denied eligibility for that program. (Complaint, Appendix E at App-34 - 35). Upon this basis, plaintiffs sued the state complaining that defendants' failure to treat certain patients as "heavy cost" patients violated state law and Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*

The case was assigned to a United States Magistrate for findings and recommendations. On the facts alleged, Magistrate Hogan determined that 42 U.S.C. §§ 1396 *et seq.* did not create enforceable rights or a private right of action and that plaintiffs, therefore, could not sue under 42 U.S.C. § 1983. The District Court of Oregon, Honorable Judge Burns, adopted the magistrate's findings and recommendations and dismissed plaintiffs' complaint with prejudice and without leave to amend.

Plaintiffs appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit held that plaintiffs' complaint stated a claim for statutory entitlement cognizable under 42 U.S.C. § 1983. The Ninth Circuit, therefore, reversed and remanded this case for further proceedings.

REASONS FOR GRANTING THE WRIT

The Ninth Circuit's determination that plaintiffs' allegations raise federal rights enforceable under 42 U.S.C. § 1983 has jarring implications for federal-state relations in the administration of cooperative funding programs. Although the issues arise in the particular context of the Medicaid program established by Title XIX of the Social Security Act, they transcend the narrow setting of this particular statutory scheme.

In determining what remedies Congress intended to make available for enforcement of the Medicaid program, the Ninth Circuit declares it *irrelevant* that: (1) Congress in the enactment expressly requires the states to establish corrective administrative processes; (2) those processes must be reviewed and approved by the federal government; (3) states devote considerable resources to providing administrative remedies tailored to resolve the very claims plaintiffs seek to adjudicate in federal court; and (4) those are the only remedies expressly contemplated by the congressional enactment and federal implementing regulations. Moreover, the Ninth Circuit silently accepts the proposition that Congress intends the creation of *federal* rights even when Congress itself declines to set specific levels of benefits under the scheme and instead purposely calls on the states to exercise independent judgment and discretion to create specific entitlements. In accepting that proposition, the lower court's decision ignores the serious Eleventh Amendment concerns raised. The result in this case is disturbing, not only because it upsets the cooperative balance struck by Congress and effectively robs the states of their contemplated role, but also because the Ninth Circuit reaches this result on such barren analysis.

This Court's decisions should have guided the Ninth Circuit in charting a true course. In *Maine v. Thiboutot*, 448

U.S. 1 (1980) this Court held that 42 U.S.C. § 1983 was available to enforce state violations of federal statutes. Since that decision, both this Court and lower courts have grappled with the outer limits of that holding. Although *Thiboutot* arguably could be read to permit recourse to a § 1983 action for any violation of federal statute (*see, e.g.*, dissenting opinion of Powell, J., in *Maine v. Thiboutot*), subsequent decisions have established that § 1983 enforcement of federal statutes is a more limited proposition. *See, e.g., Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981) (*Pennhurst I*) and *Middlesex County Sewerage Authority v. National Sea Clammers Assn.*, 453 U.S. 1 (1981) (*Middlesex*) (§ 1983 is not available to remedy statutory violations where Congress has foreclosed such enforcement in the enactment itself or where the statute does not create rights within the meaning of § 1983). The key to the inquiry is congressional intent, and the analysis should turn on a meaningful search for that intent. *See generally Wright v. City of Roanoke Redevelopment and Housing Authority*, ___U.S. ___, 107 S. Ct. 766 (1987). Since *Thiboutot*, this Court has suggested that the number of statutory enactments enforceable through § 1983 are few, rather than many. *See Garcia v. Wilson*, 471 U.S. 261, 278-79 (1985).

To date, this Court has not addressed the availability of § 1983 to adjudicate rate reimbursement disputes under the federal Medicaid program. Nor has the Court, in determining § 1983 jurisdiction, considered the significance of the existence of congressionally mandated state administrative remedies approved by the United States Department of Health and Human Services and the question whether claims brought under the state-crafted provisions of public aid plans invoke federal rights.

Resolution of these questions by this Court is important because the states, all of which participate in the Medicaid program, are entitled to know the scope of their exposure to

suit in federal court. Additionally, lower federal circuit and district courts need guidance in this area. Judicial responses to § 1983 actions brought to adjudicate rate reimbursement disputes under the Medicaid Act are differing and confused, and the case results are frequently at odds. For these reasons, this Court should grant certiorari.

I

A. The Ninth Circuit's wholesale disregard of Oregon's administrative remedies frustrates the spirit and purpose of the cooperative Medicaid scheme.

1. *The Medicaid Structure*

The Medicaid program is a cooperative federal-state fund matching scheme set up to provide medical services to the poor.[4] One of the important components of the program is the assistance provided indirectly to institutionalized patients through funds channeled to long-term care facilities (LTCF's). This is achieved by reimbursing LTCF's at a rate established by each individual state and approved by the Department of Health and Human Services Health Care Financing Administration (HCFA). 42 U.S.C. §§ 1396, 1396a(a)(13)(A).

Under the program, primary responsibility for development and administration of a Medicaid plan rests with the individual states. Within the limits of the Medicaid Act and the implementing regulations, each state determines eligibility requirements for the program, develops criteria for qualifying health care providers, determines the scope and duration of services provided to patients, and sets rates for reimbursement. *See generally Briarcliff Haven, Inc. v. Dep't of Hum.*

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[4] Federal requirements for the program are set out in Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396p.

Res., Ga., 403 F. Supp. 1355, 1358 (N.D. Ga. 1975) and discussion therein.

State discretion regarding the content and scope of the state's plan gradually has expanded with the Medicaid Act's evolution. This is particularly so in the setting of reimbursement rates for LTCF's. Originally, states were required to reimburse LTCF's for inpatient services on the basis of cost methodology used by the federal Medicare program. *Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511, 515 (5th Cir. 1983). In 1972, in response to concerns about spiraling costs, Congress amended Title XIX by insertion of a "reasonable cost related standard" for reimbursement designed to allow, and even encourage, each state to develop its own alternative reimbursement scheme *Id.*[5] In 1980, Congress replaced that standard with the current requirement that each state develop reimbursement rates that the state finds, and the federal oversight agency agrees, are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . ." 42 U.S.C. § 1396a(a)(13)(A) (as amended by the Omnibus Budget Reconciliation Act of 1980, Public Law 96-499, § 962). This amendment was designed to expand even further the states'

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[5] *See* Public Law 92-603, § 249. With the 1972 amendment, Congress substantially broadened state administrative discretion. As discussed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula. See S.Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972). . . . Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

discretion in developing and implementing reimbursement methodologies.[6]

State plans thus are highly individualized and variable. Each state exercises primary authority over the contents and the administration of its plan. HCFA possesses responsibility for reviewing and approving a state's proposed plan. But in meeting this responsibility the federal agency has acknowledged the essential role of state discretion in areas such as reimbursement rate-setting. *See* 48 Fed. Reg. 56047 (December 19, 1983).

Consistent with the states' role, Congress and HCFA have mandated the existence of certain administrative structures at the local level. For example, each state must administer its plan through a special state agency. 42 U.S.C. § 1396a(a)(5). Of particular relevance here, states also must establish administrative hearing processes for patient benefit challenges and a provider appeals process for reimbursement decisions. 42 U.S.C. §§ 1396a(a)(3) and 1396a(a)(37); 42 C.F.R. §§ 431.220, 431.241, 431.246 and 447.253(c). Because state plans vary so widely, HCFA leaves it to the states to determine the precise appeal procedures that will best comple-

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[6] The "Boren Amendment" standard was extended to hospitals as well as other long-term care facilities in 1981. Public Law 97-35, § 2173. As the legislative history reflects:

> In eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981).

ment their chosen reimbursement system.[7] But, pursuant to Congress' mandate in the Medicaid Act, HCFA reviews and approves the state's adopted administrative procedures in approving the state plan. 42 U.S.C. § 1396.

The "right" granted under the federal enactment is, accordingly, not just the right to funding for medical costs; it includes also the right to a state forum to challenge state reimbursement decisions. The Ninth Circuit is thus flatly wrong in its statement that "Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements." 803 F.2d at 1062 (emphasis added). The lower court is equally wrong in its characterization of the state administrative remedies as "complementary." 803 F.2d at 1062, n. 2. State administrative remedies are *required* under the Medicaid program. Those remedies are reviewed and approved by HCFA as a condition of state participation in the program. As the only remedy expressly provided for by Congress and approved by HCFA, the state remedies certainly must be deemed primary.

2. *The Oregon Administrative Hearing and Review Structure.*

Oregon's administrative review procedures comply fully with the federal mandate, evidencing Oregon's commitment

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[7] In commenting on the regulations requiring provider appeals of state rate determinations, HCFA concluded that "the States, not the Federal government, are in the best position to determine the administrative process that would best meet their needs and be most compatible with the reimbursement system. *See* 48 Fed. Reg. 56047 (December 19, 1983). As the agency further noted:

> Since the Medicaid program is State administered, it is neither appropriate nor administratively feasible to establish a Federal appeals process outside the current State administrative procedures or the State and Federal civil court systems. Finally, absent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available in their States after they have exhausted the administrative appeal process.

Id.

to its responsibility for administering its plan and its interest in ensuring correct administrative decisions. By administrative rule, health care providers and facility residents may challenge agency reimbursement and benefit decisions and receive administrative review.[8] If they are dissatisfied with the results of the administrative process, they can further adjudicate their claim in state court pursuant to the Oregon Administrative Procedures Act, Or. Rev. Stat. ch. 183.[9] Thus, providers and patients aggrieved by state benefit and reimbursement decisions may seek correction of those decisions through both administrative and judicial remedies available at the state level as a matter of right.

3. *By-Pass of State Administrative Remedies Frustrates the Medicaid Program.*

The state argued to the Ninth Circuit that the federally mandated existence of a comprehensive state remedial scheme was a key factor in determining Congress' intent and, thus, the availability of a § 1983 remedy in this case. The Ninth Circuit casually dismissed that argument in a footnote, declaring that the availability of a state administrative remedy was "not relevant." 803 F.2d at 1062, n. 2. Such cavalier disregard of the existence of remedies placed by design into the statutory scheme offends common sense and is legally unsound. The fact that Congress required states to provide

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[8] *See, e.g.*, Or. Admin. R. 461-09-000 (Fair Hearing Definitions), Or. Admin. R. 461-09-010 (The Hearing Request), Or. Admin. R. 461-09-011 (Group Fair Hearings), and Or. Admin. R. 411-70-435 (Provider Appeals). These administrative rules are set out in Appendix I.

[9] Oregon by statute has provided for judicial review of administrative agency decisions, if a party wishes to contest the agency decision. The provisions contained in Or. Rev. Stat. §§ 183.482 and 183.484 are set out in Appendix J.

administrative remedies is a legitimate guide in the inquiry into congressional intent. *Cf. Wright v. City of Roanoke Redevelopment and Housing Authority*, ___ U.S. ___, 107 S. Ct. 766, 771 (1987) (centralization of enforcement authority and existence of comprehensive remedial mechanisms are relevant to Congress' intent to foreclose § 1983 remedy).

The Medicaid enactment establishes a true cooperative state-federal funding scheme in which both sovereigns contribute resources to achieve a common goal. Congress' intent, reflected in the scheme's very structure, is that state administrative errors be corrected promptly by the state. When, as here, Congress and the federal agency have mandated the existence of state corrective remedies, Congress' intent necessarily is that those remedies be used. However, the necessary consequence of the Ninth Circuit's ruling is that providers and patients need never avail themselves of those state processes.

Congress' desire to have rate reimbursement challenges litigated at the state level is underscored by its repeal, in 1976, of a provision of the Medicaid program requiring participating states to waive immunity to federal court suits brought by providers. 42 U.S.C. § 1396(g) (repealed).[10] Congress' rationale in repealing the provision was to avoid an "unreasonable burden of suits . . . which will make efficient program administration virtually impossible." *Hosp. Ass'n of New York v. Toia*, 435 F. Supp. 819, 825 (S.D. N.Y. 1977). More-

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[10] 42 U.S.C. § 1396(g) (repealed) provided:

> Notwithstanding any other provision of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subject (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise.

over, Congress seriously questioned the constitutionality of a provision waiving the states' Eleventh Amendment immunity. *Id.* at 824. Thus, the Ninth Circuit's decision contravenes the Medicaid program's history, as well as its current structure.

The result reached in this case similarly frustrates state expectations and interests. To discount a comprehensive state remedial scheme as irrelevant shows no respect for the central role of each state in administering its state plan. States develop their plans, staff their agencies and implement their administrative processes at substantial expense. As one of two sovereigns in the compact, each state has an interest at least equal to that of the federal government in correcting errors in a plan's administration. Given their primary role in fashioning and implementing the plans, the states' interests in fact are weightier. When a state invests its efforts and resources to implement remedial processes specifically contemplated by the federal act, the state, too, is entitled to expect that those processes will be used. It is an affront to the integrity of those state processes and the sincerity of the states' efforts to suggest that state administrative remedies are not worth consideration.

The Ninth Circuit's holding widely opens federal court doors to these claims and threatens a severe burden on state resources and on federal court dockets. Rate reimbursement decisions are not one-time events. Providers are reimbursed for their costs on a periodic basis, often annually or semi-annually. Litigating these periodic decisions through § 1983 actions will heavily tax federal district courts and state resources. Imposing the heavy cost of federal court litigation on the states is particularly unfair when, at federal behest, they have also borne the burden of establishing a state remedial scheme that resolves reimbursement disputes more

rapidly and does not pose Eleventh Amendment impediments to complete relief. *Dep't of Health v. Florida Nursing Home Ass'n*, 450 U.S. 147 (1981) (Eleventh Amendment bars suit in federal court for retroactive Medicaid payments). Ultimately, because this holding means that state administrative remedies either will sit idle or prove merely duplicative, the result is wasteful as well.

B. Lower federal courts have reached different conclusions on the availability of § 1983 relief for alleged Medicaid rate violations under divergent analyses that demonstrate the need for this Court's guidance.

Congressional intent is and should be the polestar in determining the availability of § 1983 relief for an alleged violation of federal statute. The Ninth Circuit, however, made little effort to search for that intent. It concluded first that *Maine v. Thiboutot* governs all actions to enforce any provision of the Social Security Act and that *Pennhurst I*, *supra*, and *Middlesex*, *supra*, are inapplicable. 803 F.2d at 1061. However, apparently as a cautionary measure, the lower court undertook a *Pennhurst I* analysis. Congress' intent, the court concluded, was not to foreclose a § 1983 action since no judicial or federal administrative remedies were expressly mandated. The court also found the rights at stake to be of the kind enforceable under § 1983, for providers and patients alike. 803 F.2d at 1062-63.

The Ninth Circuit is not alone in its analysis. Other courts, too, have read the *Thiboutot* decision broadly to sanction § 1983 actions brought to enforce any provision of the Social Security Act. Some of these decisions fail altogether to discuss the limiting doctrines of *Pennhurst I* and *Middlesex*. *E.g.*, *Mitchell v. Johnson*, 701 F.2d 336, 344 (5th Cir. 1983); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295-96 (8th Cir. 1985) *cert. denied*, ___ U.S. ___, 107 S.

Ct. 947 (1987). At least one other federal court has held that suits to enforce the Medicaid statute are generally unaffected by the *Pennhurst I* decision. *In re Greenwald*, 603 F. Supp. 45, 51-52 (S.D. N.Y. 1984).

A substantial body of federal authority has reached a directly opposite result, however. Although these courts have not done so under a *Pennhurst I* analysis, they have meaningfully inquired into the spirit and purpose of the Medicaid act and have resolved the issue in a way calculated to effectuate congressional intent.

Several lower federal courts have held that available administrative remedies must be exhausted before bringing a federal court action to enforce the Medicaid program. They have imposed this requirement pursuant to *Parratt v. Taylor*, 451 U.S. 527 (1981), where, as here, plaintiffs cast their claims exclusively or alternatively as due process denials. *See, e.g., Oberlander v. Perales*, 740 F.2d 116, 120-22 (2d Cir. 1984). Other courts have required exhaustion pursuant to traditional principles of comity and judicial economy. *See, e.g., Al-Charles, Inc. v. Heintz*, 620 F. Supp. 327, 331 (D.C. Conn. 1985).[11] As explained by one district court in rejecting, in this context, the general rule that exhaustion is not a prerequisite to § 1983 claims:

> [T]he *Patsy* [*v. Board of Regents*, 457 U.S. 496 (1982)] doctrine should not apply to a case when the lawsuit arises out of federal statutes enacted after § 1983 which contemplate or require that the state will institute or provide administrative review procedures. . . . In this case, the Medicaid Act expressly

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[11] *See also Arden House, Inc. v. Heintz*, 612 F. Supp. 81, 85-86 (D.C. Conn. 1985); *St. Joseph Hosp. v. Electronic Data Systems Corp.*, 573 F. Supp. 443, 450 (S.D. Tex. 1983); *Ryans v. New Jersey Commission for the Blind*, 542 F. Supp. 841, 850 (D. N.J. 1982); *Fuzie v. Manor Care, Inc.*, 461 F. Supp. 689, 696 (N.D. Ohio E.D. 1977).

> contemplates administration and management of the Medicaid Program by the states. *See e.g.*, 42 U.S.C. § 1396a(a)(4,5). If we were to accept the Plaintiffs' arguments to the contrary, the exhaustion requirement embodied in both the Texas and federal Administrative Procedure Acts would be reduced to meaningless charades since those Acts could be circumvented by merely "crying 1983." We decline to do so.
>
> The exhaustion doctrine contemplates that the real issues in controversy be presented to the administrator, that he be given the opportunity to apply his special skills and experiences to them, that he be permitted to correct errors and that resort to the courts be had only thereafter. . . . This set of considerations forms the crux of the exhaustion requirement.

St. Joseph Hosp. v. Electronic Data Systems, supra, 573 F. Supp. at 450. As another district court has observed, any other result would be inconsistent with Congress' intent to dissuade suits in federal court as evidenced by the repeal of the Medicaid provision requiring state waiver of immunity. *Arden House, Inc. v. Heintz, supra*, 612 F. Supp. at 85-86. But, concededly, lower federal court authority is split on whether exhaustion principles should apply. *See, e.g., Alacare, Inc.-North v. Baggiano*, 785 F.2d 963, 967-70 (11th Cir. 1986); *In re Greenwald*, 603 F. Supp. 45, 51-52 (S.D. N.Y. 1984).[12]

Additionally, some federal courts have dismissed § 1983 actions brought to enforce Medicaid claims under the abstention doctrine of *Burford v. Sun Oil*, 319 U.S. 315 (1943). *See, e.g., New York State Ass'n. for Retarded Children v. Carey*, 727 F.2d 240, 245 (2d Cir. 1984); *Arden House, Inc. v. Heintz*,

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[12] *See also Colorado Health Care Ass'n. v. Colorado Dept. of Soc. Serv.*, 598 F. Supp. 1400, 1406 (D. Colo. 1984); *Georgia Hospital Ass'n v. Dept. of Med. Assistance*, 528 F. Supp. 1348, 1353 (N.D. Ga. 1982); *Mendoza v. Lavine*, 412 F. Supp. 1105, 1108-10 (S.D. N.Y. 1976).

supra, 612 F. Supp. at 86; *St. Joseph Hosp. v. Electronic Data Systems*, *supra*, 573 F. Supp. at 451-52. In doing so, these courts have demonstrated sound respect for the sovereignty of the states and their contemplated role under the cooperative state-federal Medicaid program:

> *Burford* abstention is proper when a state has established an administrative framework to formulate policy and decide cases in an area of legitimate state interest. The underlying tenets of abstention are rooted in the fundamental concepts of federalism which require the federal judiciary to refrain from hearing matters in the first instance which directly involve important state interests in order to maintain proper harmony in state-federal relations. . . .
>
> In the instant case the Medicaid Act has established a cooperative state-federal program wherein the states actually administer and oversee the payment of benefits and related matters. The State of Texas has erected an elaborate system for the administration of the program. We are therefore of the opinion that this case is one where *Burford* abstention is proper.

St. Joseph Hosp. v. Electronic Data Systems, *supra*, 573 F. Supp. at 451-52 (citations omitted).

This canvas of lower federal court cases shows that federal court decisions embody no consensus on whether or when to hear § 1983 actions asserting rights under Title XIX. However, there is one point about which there can be no dispute: Congress designed the Medicaid program so that administrative errors could be promptly corrected at the state level; Congress, therefore, must have intended for those procedures to be used. To ignore state remedies, or to cast them aside as inconsequential, directly undermines the congressional design. Yet, that is precisely the effect of the Ninth Circuit's decision in this case. Although other federal courts have reached results more in line with Congress' manifest intent, they have followed disparate analyses. This Court's

review is required in this case to bring clarity and order to an area of the law which currently stands in disarray.

II

As discussed at length in the prior section, states have the central responsibility to determine the type and amount of the benefits they will provide at the local level. With respect to reimbursement rates in particular, the federal enactment provides only that a state must use rates that the state finds are reasonable and adequate to meet the costs which must be incurred by an efficient and economically operated facility. 42 U.S.C. § 1396a(a)(13)(A). The particular rates set for specific categories of medical care unquestionably are, under the federal enactment, matters within each state's sound discretion.

The significant issue raised by this statutory structure is whether claims based on entitlements under state rate provisions, as opposed to the express provisions of the Medicaid Act itself, involve *federal* rights enforceable through a § 1983 action. Here, plaintiffs sought reimbursement for "heavy cost" services to certain Medicaid patients, a category of services that the State of Oregon has chosen to fund at a particularly high rate. Their complaint *alleged* a violation of the federal Medicaid statute. But, as the district court observed, the only state action or inaction identified was the state's asserted failure to reimburse at the state plan "add on" rate for heavy cost care, as established by state administrative rule.[13]

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[13] The magistrate below accurately described the gravamen of plaintiffs' complaint:

> [P]laintiffs' complaint contends that under the applicable state regulation and a contract with the state of Oregon Department of Human Resources, plaintiff Coos Bay Care Center is entitled to more money for the services it renders to certain heavy care

(Footnote continued on next page)

Members of this Court recently have questioned whether administrative regulations, as opposed to the underlying congressional enactment they implement, can be said to create rights enforceable under § 1983. *Wright v. City of Roanoke Redevelopment and Housing Authority, supra*, 107 S. Ct. at 775 (O'Connor, J., dissenting, joined by Rehnquist, C.J., Powell and Scalia, J.J.). The dissent in *Wright* also questioned whether regulations create judicially manageable standards, and are thus actionable under § 1983, when they direct only "reasonable" levels of benefits and delegate specific delineation of entitlements to local administrators. *Id.* at 778.

Whatever the answers may be to those difficult questions when a *federal* agency's regulations are the putative source of a claimed right and when discretion is delegated to federal administrative bodies, the problem takes on a new dimension in a federal-state cooperative program like Medicaid. The questions must be asked: How can Congress have intended to create *federal* rights when the authority to design specific entitlements rests with the independent sovereign states? How can that intent be imputed to Congress when Congress expressly deferred to *state* discretion and judgment in the development of state Medicaid plans? Did Congress intend federal courts to be placed in the position of second-guessing state discretion under the broad reasonableness standard of Title XIX?

(Footnote continued from previous page)

> Medicaid patients, who by virtue of their medical or developmental problems require significantly more care that [*sic*] the ordinary intermediate patient. OAR 411-70-030 provides *inter alia* for specific and complete reimbursement of costs for providing heavy care. The individual plaintiffs contend that they are among the "heavy care" patients residing within the Coos Bay Care Center and elsewhere who qualify for heavy care but do not receive the full range of appropriate care because of defendants' alleged refusal to appropriately reimburse health care providers for such care.

Findings and Recommendations, Appendix C at App-11).

These questions, however, were never asked or answered by the Ninth Circuit. For the Ninth Circuit, it was enough to conclude that the statutory scheme was enacted for the special benefit of the plaintiff or plaintiff class. 803 F.2d at 1063. But states do not act as mere administrative arms of the federal government. In this, as in any cooperative federal-state funding scheme, they are partners with sovereign status seeking jointly with the federal government to further a common objective. The Ninth Circuit's resolution of the issue is simply inadequate.

State participation in the cooperative scheme adds a constitutional dimension to the analysis. In the Ninth Circuit, the state argued that because plaintiffs' allegations arise under state regulations rather than under the federal Medicaid Act itself, the Eleventh Amendment protects the state from suit in federal court. The Ninth Circuit declined even to address that argument.

Although the problem never has been discussed by this Court, it unquestionably is a substantial issue that merited the Ninth Circuit's careful consideration and resolution. In *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984) (*Pennhurst II*), this Court declared that the Eleventh Amendment bars a federal court's grant of relief against state officials on the basis of state law, whether the relief sought is prospective or retroactive. That holding was driven by the recognition that federal court coercion of state action cannot, in such an instance, be justified by the need to vindicate the supreme authority of federal law. *Id.* at 106. This Court found it difficult to envision a "greater intrusion" on state sovereignty than when a federal court instructs state officials how to conform their conduct to state law; it therefore would not, consistent with principles of federalism, tolerate that intrusion. *Id.*

At least one circuit court has concluded that claims seeking to enforce a state's compliance with its own Medicaid

plan raise questions of state law only, not federal law. In *Oberlander v. Perales*, *supra*, plaintiffs argued that reduction of their Medicaid reimbursement rate violated a state rate regulation. Plaintiffs further reasoned that because the state plan must conform with the federal Medicaid statute, there was *ipso facto* a violation of federal law. The United States Court of Appeals for the Second Circuit held:

> We reject this tortuous argument, which, if valid, would provide a jurisdictional basis for federal judicial review of every disputed state administrative ruling relating to Medicaid. " '[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States,' " *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 2504, 65 L.Ed.2d 555 (1980) (quoting *Edelman v. Jordan*, 415 U.S. 651, 675, 94 S.Ct. 1347, 1362, 39 L.Ed.2d 662 (1974)), but there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law. To the contrary, every precedent cited by Flatbush Manor has involved allegations of a specific conflict between a state plan or practice on the one hand and a federal mandate on the other. . . . Since Flatbush Manor alleges no such conflict between the state plan and federal law, we dismiss the statutory claim.

Oberlander v. Perales, *supra*, 740 F.2d at 119 (citations omitted).

Here, as in *Oberlander*, plaintiffs did not base their claim on a conflict between the state plan and federal law. Their complaint sought a reimbursement rate set by Oregon for "heavy cost" care. The structure of the Medicaid Act belies any assertion that a federal mandate guarantees a particular amount of compensation for that care. Under the Second Circuit's analysis, therefore, the federal court lacked jurisdiction to adjudicate that claim.

The result in this case is squarely at odds with the law in the Second Circuit; the conflict needs resolution. The *Oberlander* decision correctly observes that if every provision of a state's Medicaid plan is deemed to give rise to a federal right within the meaning of § 1983, then all disputed state administrative decisions can be adjudicated in federal court. That conclusion plainly runs afoul of the contemplated role of the states in administering the Medicaid scheme. More important, it cannot be harmonized with the federalism principles discussed in *Pennhurst II*, *supra*. Federal court intrusion here is not necessary to vindicate important federal rights; Congress has declined to create federally any particular rate structure. Instead, Congress views the contents of a state's Medicaid plan, including reimbursement rates, as an area of primary state interest and concern. To permit, as the Ninth Circuit permits, federal courts to instruct state officials on how to conform their conduct to the state-created terms of their individual Medicaid plans has deeply disruptive implications for correct federal-state relations. This Court should grant certiorari to examine the Ninth Circuit's ill-advised course.

CONCLUSION

For the reasons given above, the Court should issue a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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APPENDIX A

COOS BAY CARE CENTER, an Oregon Corporation; Hannah Schwanke, Guardian Ad Litem for David and Steven Schwanke, et al., Plaintiffs-Appellants

v.

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; Richard C. Ladd, Defendants-Appellees.

No. 85-4049.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Sept. 4, 1986.
Decided Nov. 3, 1986

[Names of counsel omitted in printing]

Before WRIGHT, GOODWIN, and NELSON, Circuit Judges.

GOODWIN, Circuit Judge:

A long-term health-care facility and several of its patients sued state defendants complaining that the state was violating both state laws and Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396q (1982 & Supp. III 1985). The Senior Services Division of the State of Oregon withheld from plaintiffs certain "heavy-care" Medicaid payments and reimbursements. The district court dismissed the action for failure to state a claim. Fed. R. Civ. P. 12(b)(6). Because a cognizable claim for statutory entitlement has been stated under 42 U.S.C. § 1983, we reverse and remand for further proceedings consistent with this opinion.

The Supreme Court has held that 42 U.S.C. § 1983 can provide a cause of action in federal court for the denial of

rights created by a federal statute. *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S. Ct. 2502, 2504, 65 L.Ed.2d 555 (1980). *Thiboutot* has been narrowed as applied to some federal statutes, *see Middlesex County Sewerage Auth.* [*v.*] *National Sea Clammers Ass'n*, 453 U.S. 1, 19, 101 S. Ct. 2615, 2625, 69 L.Ed.2d 435 (1981); *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 28, 101 S. Ct. 1531, 1545, 67 L.Ed.2d 694 (1981). However, *Thiboutot* still governs actions brought to compel participating states to comply with the provisions of the Social Security Act. Specifically, in this and other circuits, actions which properly allege violations of 42 U.S.C. § 1396a(a)(13)(A) are entitled to consideration on the merits. *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295-96 (8th Cir. 1985); *Washington State Health Facilities Ass'n v. State of Washington Dep't of Social & Health Servs.*, 698 F.2d 964, 965 and n.4 (9th Cir. 1982); *Yapalater v. Bates*, 494 F.Supp. 1349, 1357-58 (S.D.N.Y. 1980), *aff'd*, 644 F.2d 131 (2d Cir. 1981), *cert. denied*, 455 U.S. 908 (1982); *Thomas v. Johnston*, 557 F. Supp. 879, 902-04 (W.D. Tex. 1983).

The district court relied primarily on *Pennhurst* to dismiss plaintiffs' action. It concluded that because the language of 42 U.S.C. § 1396a(a)(13)(A) is directed mainly to allocating Medicaid program funding obligations among state and federal sources, the statute did not create rights in favor of plaintiffs that are enforceable under § 1983. We disagree. *Thiboutot* rather than *Pennhurst* governs this case, and it was not necessary to engage in a *Pennhurst* analysis. Even if *Pennhurst* properly applies here, these plaintiffs can enforce 42 U.S.C. § 1396a(a)(13)(A).

Pennhurst established two exceptions limiting the effect of *Thiboutot* on cases involving the enforcement of federal statutory rights. Access to a § 1983 remedy should be denied if (1) the language of the statute indicates a congressional intent to foreclose § 1983 enforcement by making alternative

remedies available, or (2) the statute does not create "rights" enforceable by private parties under § 1983. *Almond Hill School v. United States Dep't of Agric.*, 768 F.2d 1030, 1035 (9th Cir. 1985); *Keaukaha-Panaewa Community Ass'n v. Hawaiian Homes Comm'n*, 739 F.2d 1467, 1470-71 (9th Cir. 1984); *Boatowners & Tenants Ass'n v. Port of Seattle*, 716 F.2d 669, 671 (9th Cir. 1983).

With respect to the first exception, the focus should be on the "comprehensiveness" of a statute's remedial scheme. Specific and detailed procedures for administrative and judicial review are more likely to foreclose or preclude recourse to § 1983. *See Almond Hill School*, 768 F.2d at 1035. Here, Title XIX permits states to establish administrative review procedures for disputes over Medicaid reimbursements. However, the statute does not provide for formal federal or state judicial or federal administrative review procedures. Indeed, in some cases, judicial review of such matters has been achieved only by permitting an "implied" right of action to be drawn out of the language of the statute itself. *See California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983)(42 U.S.C. § 1396a(a)); *California Hospital Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979)(42 U.S.C. § 1396a(a)(13)(A)).[1]

Although state violations of Title XIX may be remedied by means of the cut off of federal funding for a state's programs, this generalized remedial opportunity is not sufficiently precise to preclude remedies otherwise properly available under § 1983. *SeeKeaukaha-Panaewa*, 739 F.2d at

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[1] It is not a bar to a § 1983 action that a private right of action cannot be "implied" from the federal statute itself. *Keaukaha-Panaewa*, 739 F.2d at 1470. Rather, an independent § 1983 inquiry is required because " 'there could well be federal rights enforceable under section 1983 which are not enforceable by means of a private right of action under the statute creating them.' " *Id.* (quoting *Boatowners*, 716 F.2d at 674).

1471.[2] We conclude that the first *Pennhurst* exception should not bar this action.

The second *Pennhurst* exception examines the character of the "right" created by a federal statute. In *Boatowners*, we indicated that a useful method to determine whether a statutory "right" is sufficiently important for § 1983 enforcement is to borrow from the "implied" right of action line of authority. *Boatowners*, 716 F.2d at 672. In essence, we examine whether a statute meets the first of the four elements required by *Cort v. Ash*, 422 U.S. 66, 95 S. Ct. 2080, 45 L.Ed.2d 26 (1975), for recourse to private enforcement under an "implied" right of action theory. *Boatowners*, 716 F.2d at 672. The first *Cort* element considers whether a statute was enacted for the special benefit of a plaintiff or a plaintiff class. Borrowing from *Cort*, this circuit has stated that if a plaintiff is one of a class for whose special benefit a statute was enacted, and if Congress has not expressly proscribed private actions to enforce the benefit, the entitlement will support a plaintiff's § 1983 action. *Keaukaha-Panaewa*, 739 F.2d at 1471; *Boatowners*, 716 F.2d at 673, 672-73 (citing *Cort v. Ash*, 422 U.S. 66, 95 S. Ct. 2080, 45 L.Ed.2d 26 (1975)); *Fisher v. City of Tucson*, 663 F.2d 861, 863 (9th Cir. 1981), *cert. denied*, 459 U.S. 881, 103 S. Ct. 178, 74 L.Ed.2d 146 (1982).

Plaintiffs in this action are a private health-care facility and individual Medicaid patients residing in the facility. Patients confined by illness, disability, or age to a long-term health-care facility are intended beneficiaries of the Medicaid statutes in general and 42 U.S.C. § 1396a(a)(13)(A)

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[2] We decline to review the state administrative procedures and contractual remedies assertedly available to plaintiffs under Oregon law. In a § 1983 *Pennhurst* analysis, we are bound to consider only those remedial procedures established by the federal statute in issue. Complementary state procedures and remedies are not relevant.

in particular. Private health-care providers caring for Medicaid patients, such as Coos Bay Care Center, also have a direct financial interest in the availability of Medicaid reimbursement. In several similar cases, courts have permitted providers to bring actions to enforce the Medicaid statutes. *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979); *Massachusetts Gen. Hosp. v. Weiner*, 569 F.2d 1156 (1st Cir. 1978); *California Ass'n of Bioanalysts v. Rank*, 577 F.Supp. 1342, 1347 n.6 (C.D. Cal. 1983). These cases have recognized that Medicaid patients and health-care providers have parallel interests with respect to Medicaid funding and reimbursement. No reason has been advanced to justify the denial of a health-care provider's right to stand as co-plaintiff with individual Medicaid recipients in this action.

We do not suggest that plaintiffs in this action necessarily will prevail on the merits of their claim. We do not reach the merits. Rather, we hold simply that statutory rights under Title XIX of the Social Security Act have been alleged in the complaint which are sufficient to state a claim under 42 U.S.C. § 1983. To prevail on the merits, plaintiffs must convince the trial court that the actions and non-action of the State of Oregon violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A). We do not reach the other issues raised in this appeal.

Reversed and remanded.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

[names of counsel omitted in printing]

COOS BAY CARE CENTER, an Oregon Corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem, for David and Steven Schwanke; and SANDY MAUER, et al,	)	Civil No. 84-6178-C
Plaintiff,	)	ORDER
v.	)	
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

After a *de novo* review of the file in this matter, I adopt the Magistrate's Findings and Recommendation filed April 8, 1985.

This matter was heard by telephone conference on May 22, 1985, Mr. Hall standing in for Mr. Lojek appeared with Mr. Saalfeld for plaintiffs, and defendants were represented by Assistant Attorney General Thomas K. Elden. After oral argument and being fully advised in the premises, I stated that

I approved and adopted the Findings and Recommendation of the Magistrate *in toto* and held that the Complaint and action be dismissed. Counsel for plaintiffs indicating that they do not require an opportunity to replead, it is hereby

ORDERED that plaintiffs' Complaint including the class action allegations therein is dismissed with prejudice and without leave to amend.

[signature omitted in printing]

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

COOS BAY CARE CENTER, an Oregon Corporation, (Guardian Ad Litem); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,	)	
Plaintiffs,	)	Civil No. 84-6178-C
v.	)	FINDINGS AND RECOMMENDATION
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD, in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

[Attorneys names omitted in printing]

HOGAN, Magistrate:

This is a class action for alleged violations of plaintiffs' rights under the U.S. Constitution and other state and federal laws with a pendent state claim for alleged breach of con-

tract. Plaintiffs seek damages as well as declaratory and injunctive relief.

In essence, plaintiffs contend that the Coos Bay Care Center is under OAR 411-70-030 and a contract with the Senior Services Division of the state of Oregon Department of Human Resources, entitled to more money for services rendered to certain persons eligible for state and federal medical assistance.

Defendants now move the court for an order pursuant to Fed. R. Civ. P. 12(b)(1), 12(b)(6) and 12(e) dismissing plaintiffs' complaint for failure to state a claim and lack of jurisdiction, and, in the alternative, to make certain portions of the complaint more definite and certain.

The following background is essential to an understanding of the issues in this case. Plaintiff Coos Bay Care Center is an intermediate care facility providing long-term health care services for the developmentally disabled and the aged that participates in the 42 U.S.C. § 1396(a) et seq. (Title XIX) Medicaid program. Medicaid is a jointly funded federal-state program designed to render health care services to the poor. Under the program, the cost of maintaining a Medicaid patient is paid by the state, which in turn receives partial reimbursement from the United States Department of Health and Human Services. Approximately two-thirds of the cost of the program is met by the federal government, with the remainder coming from Oregon legislative appropriations. Participating health care providers, such as plaintiff, were formally [*sic*] paid under a cost reimbursement system, whereby the provider was reimbursed a percentage of its costs based on its census of Medicaid patients. Thus, for example, if the patient population of a long-term health care facility was comprised of fifty percent private paying patients and fifty percent Medicaid patients, then fifty percent of the providers cost would be met by the state of Oregon. This

system was mandated by federal law effective July 1, 1976. Social Security Amendments of 1972, Public Law No. 92-603, Section 249. The reimbursement system was changed in 1980 by the Omnibus Reconciliation Act of 1980 (Pub. Law. 96-499) which eliminated the requirement that the state pay for Title XIX health care services on a reasonable cost related basis. The new statutory standard requires that participants in the Medicaid program be paid through the use of established rates determined in accordance with methods and standards developed by the state and

> which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide case [*sic*] and services in conformity with the applicable State and Federal laws, regulations and quality and safety standards. . . . 42 U.S.C. § 1396a(a)(13)(A).

As noted *supra*, plaintiffs' complaint contends that under the applicable state regulation and a contract with the state of Oregon Department of Human Resources, plaintiff Coos Bay Care Center is entitled to more money for the services it renders to certain heavy care Medicaid patients, who by virtue of their medical or developmental problems require significantly more care that [*sic*] the ordinary intermediate patient. OAR 411-70-030 provides *inter alia* for specific and complete reimbursement of costs for providing heavy care. The individual plaintiffs contend that they are among the "heavy care" patients residing within the Coos Bay Care Center and elsewhere who qualify for heavy care but do not receive the full range of appropriate care because of defendants' alleged refusal to appropriately reimburse health care providers for such care.

I. *Plaintiffs' first cause of action alleges that defendants' conduct "violates 42 U.S.C. § 1396(a) et seq. and 42 CFR § 447.252."*

Defendants contend that the Medicaid statutes and regulations create no substantive, enforceable rights and move to dismiss plaintiffs' first cause of action pursuant to *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) and *Beecroft v. Atiyeh*, No. 78-1027-BU (D.Or. April 16, 1982).

In *Pennhurst*, *supra*, the Supreme Court held that the Developmentally Disabled Assistance Bill of Rights Act of 1975 (42 U.S.C. § 6000 et seq.) did not create any substantive rights for the mentally retarded. The court's rationale was that nothing in the overall or specific purpose of the Act revealed an intent to require states to fund new substantive rights or to impose upon the states the obligation to fund certain levels of treatment.

Judge Burns apparently applied a similar rationale in *Beecroft*, *supra*, wherein he held

> *Pennhurst* shows that an examination of a statute's language structure and legislative history assist in determining when a right is created. *Id.* at 1540. In the instant case, these indicate no enforceable rights were created by Title XIX.
>
> Title XIX is basically a federal/state funding statute. Its language shows that its purpose is to assist the states in funding systems they develop and supervise. It says nothing of creating new, substantive rights for any individual or class. Its structure reflects administrative procedures and program requirements, not broad declarations of individual rights. Likewise, the legislative history does not indicate an intent to create rights. Thus, no substantive rights were created under either statute. *Beecroft*, *supra*, at 8.

In addition, Judge Burns held that no private right of action, expressed or implied, may be claimed under the Medicaid act or the regulations promulgated thereunder. Therefore,

assuming arguendo that Title XIX and its statutes and regulations create substantive rights, previous authority in this district indicates none of the plaintiffs herein have a private right of action to enforce those rights.

While according Judge Burns "due respect" and acknowledging his "scholarly and concise analysis" of *Pennhurst*, plaintiffs disagree with his conclusion in *Beecroft* and contend that the case of *Maine v. Thiboutot*, 448 U.S. 1 (1980) mandates an opposite conclusion than that reached by Judge Burns.

Although plaintiffs' argument is cogent and somewhat persuasive, I decline to "overrule" Judge Burns, who considered *Maine v. Thiboutot* in *Beecroft* and directly addressed the precise issue presented in the case at bar and decided it against plaintiffs' position. I follow *Beecroft* and find that plaintiffs are precluded from asserting a cause of action for alleged violations of Title XIX.

Because I find the foregoing issues dispositive, I need not address defendants' third argument with regard to plaintiffs' alleged failure to exhaust state administrative remedies.

Defendants' motion to dismiss plaintiffs' first cause of action should be granted.

II. *Plaintiffs' third cause of action alleges that defendants' conduct violates plaintiffs' constitutional rights pursuant to 42 U.S.C. § 1983.*

Defendants move to dismiss plaintiffs' third cause of action on the ground that no claim for relief has been stated.

Plaintiffs allege that they have been deprived of property without due process. To state a claim for deprivation of procedural due process rights under the Fourteenth Amendment, plaintiffs must establish the existence of some "life, liberty or property" interest within the meaning of the due process clause. *Ingraham v. Wright*, 430 U.S. 651 (1972). To have such a protected property interest a person must have

more than an abstract need or desire for it or unilateral expectation of it. He must have a "legitimate claim of entitlement to it." *Board of Regents v. Roth*, 408 U.S. 564 (1972) at 561.

As noted *supra* in *Beecroft*, Judge Burns concluded that Title XIX created no substantive rights and held that plaintiffs were precluded from attempting to "enforce" Title XIX by way of 42 U.S.C. § 1983.

Therefore, neither the residents of the Coos Bay Care Center nor the Center itself have a "legitimate claim of entitlement" to an increased funding level or a different funding mechanism.

Defendants' motion to dismiss plaintiffs' third cause of action should be granted.

III. *Plaintiffs' second cause of action is a pendent state claim under Oregon law for alleged breach of contract.*

Plaintiffs contend that defendants are in breach of the May 5, 1982, agreement between the Coos Bay Care Center and the state of Oregon to provide care as an intermediate care facility.

Defendants contend that plaintiffs' second cause of action is jurisdictionally barred by the Eleventh Amendment.

I need not address the merits of the parties' argument with respect to the application of the state of Oregon's immunity under the Eleventh Amendment.

Despite defendants' assertion to the contrary, I find that plaintiffs' second cause of action is a pendent state claim. Pursuant to my findings above, no basis for federal jurisdiction exists in this case. Although the court has discretion to retain jurisdiction over pendent state claims after dismissing federal claims, I find that it is not appropriate to do so in the case at bar. I find that the state courts of the state of Oregon are a more appropriate forum for the resolution of

plaintiffs' breach of contract cause of action. Accordingly, plaintiffs' second cause of action should be dismissed.

CONCLUSION

Based on all of the foregoing, defendants' motion to dismiss plaintiffs' complaint (#9) should be granted. Plaintiffs' complaint should be dismissed in its entirety as to all defendants. Defendants' alternative motion to make more definite and certain should be denied as moot.

DATED this 28th day of March, 1985.

[Signature omitted in printing]

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

DORCUS BEECROFT, et al.,	)	
	)	
Plaintiffs,	)	Civil No.
	)	78-1027-BU
v.	)	
	)	
VICTOR ATIYEH, in his official capacity as Governor of Oregon; LEO HEGSTROM, in his official capacity as Administrator of Human Resources Department; KEITH PUTMAN, in his official capacity as Director of the Division of Adult and Family Services; WILLIAM BROWN, in his official capacity as Assistant Director of the Division of Adult and Family Services; and J.H. TRELEAVEN, M.D., Administrator of the Mental Health Division,	)	OPINION
Defendants.	)	

HISTORY

This suit represents a challenge to Oregon's reimbursement of private intermediate care facilities for the mentally retarded (ICR/MR). It began in November of 1978 when plaintiffs, residents of Suislaw [*sic*] Care Center (one of the

private Large Residential Treatment Facilities in Oregon), sought declarative and injunctive relief from the state's reimbursement formula.

The reimbursement formula, developed by Oregon to comply with federal law, sets the rate at which the state reimburses private facilities for the shelter and care of plaintiffs and other similarly situated individuals. The challenged formula replaced the state's prior practice of reimbursing for the actual cost of all services, a more generous arrangement.

Plaintiffs, four residents of Siuslaw, contend that their rights established by federal law were violated by the Model Budget Plan (the state's reimbursement formula), which seriously reduced the amount of reimbursement. Their facility, Siuslaw, had received approximately $74 per resident per day during the latter half of 1977 and into 1978. Under the Model Budget effective November 1, 1978, Siuslaw's reimbursement fell to less than $39 per resident per day.

This reduction, they maintain, occasioned a substantial reduction in services and a frustration of the congressional intent to normalize the living environment of the retarded and the developmentally disabled. Specifically, plaintiffs assert that the reduced compensation hindered the transition from large state institutions to less restrictive, more responsive community-based facilities which the federal government intended to foster.

Historically, institutionalization had been society's primary response to the mentally retarded. In Oregon this had meant confinement to state institutions, Fairview or Eastern Oregon State Hospital. The state provided basic necessities; but little was done to train, educate or otherwise prepare the mentally retarded for a life in a different setting.

Beginning in 1972 through Title XIX of the Social Security Act of 1972, as amended, 42 U.S.C. § 1396 et. seq. (Title XIX), the federal government offered to assist states in

developing alternative approaches for treating the mentally retarded. The objective was to enhance the process of normalization and to provide shelter in the "least restrictive environment." The program sought to create environments, Intermediate Care Facilities/Mentally Retarded (ICR/MR), where individuals would be allowed to make decisions without the restrictions imposed by large institutions. In theory, the retarded persons would be encouraged and assisted to gain the skills necessary to move into progressively less restrictive environments.

To this end, Title XIX made available federal funds to states wishing to provide small community-based facilities. When the program started, Oregon's state facilities, as stated, then consisted of Fairview (about 1,400 residents) and Eastern Oregon State Hospital (about 375 residents). Few community-based facilities existed. The introduction of this program, however, spurred the growth of community facilities in Oregon. By early 1978 there were eleven such community facilities, in addition to Fairview and Eastern Oregon State Hospital.

Under federal regulations, states participating in the Title XIX assistance program are required to reimburse qualified providers (ICF/MR) for the "reasonable cost" of their care. A facility requesting reimbursement is audited by the state and allowed its "reasonable cost." Before the present Model Budget Plan went into effect November 1, 1978, providers in Oregon were reimbursed for the actual costs incurred without an upper limit.

By late 1977, it was apparent that the number of facilities and the unexpectedly high costs being incurred, would produce a serious deficit in the program's 1977-79 state budget (July 1, 1977 - June 30, 1979). As a result, a task force of Oregon officials was formed to study the situation and to

prepare a reimbursement scheme which would avoid or ameliorate the projected deficit.

This task force developed the Model Budget Plan, which governed the state's reimbursement policies. The Model Budget recognizes three separate types of facilities: SRFTs [*sic*], Small Residential Treatment Facilities (less than 15 residents comparable to group homes); LRTFs, Large Residential Treatment Facilities (15 to 200 residents, the community-based facility, of the type in which plaintiffs reside); and FSRTF, Full Service Residential Treatment Facilities (the state institutions of Fairview and Eastern Oregon State Hospital).

For each a "base cost," excluding salaries, was established. "Base cost" is the cost of funding comparable nursing homes with an additional percentage (10% of LRTFs and 5% for SRTFs) added as compensation for the special needs of the mentally retarded. In the LRTF involved in this litigation, the base cost is the non labor expense of running an institution with less than 200 beds.

The base cost is multiplied by the number of residents and the number of days in the month, and that amount is paid by the state to each facility as "provider payments." Under Title XIX, the federal government reimburses a state for these provider payments through federal matching funds. Reimbursement, however, is conditioned upon compliance with a variety of federal regulations including approval of a state reimbursement plan.

This state plan must be approved before a state contracts with qualified providers to furnish care and shelter. In turn, the ICF/MR facilities must comply with standards specified by the federal and state governments; reimbursement is conditioned upon compliance.

Congress established an administrative structure to regulate and implement reimbursement. Reimbursement is keyed

to an approved state formula. It is Oregon's reimbursement formula which plaintiffs challenge.

ISSUES

Plaintiffs maintain the method adopted by Oregon for reimbursement is invalid due to substantive and procedural defects. Plaintiffs claim these defects violate their rights under both Title XIX and the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6000 et. seq., DABRA. Specifically plaintiffs claim:

First, the Model Budget Plan does not:

(A) comply with the federal objective of enhancing normalization or providing the least restrictive environment.

(B) reimburse Siuslaw on the basis of "reasonable costs."

Second, the Model Budget Plan was adopted without consultation with the State Medical Care Advisory Commission as mandated by federal regulation.

Third, as a pendent claim, plaintiffs assert:

(A) the Model Budget Plan was promulgated without requisite notice and comment required by Oregon law.

(B) any such notice was a sham since the agency decided upon the Model Budget prior to what comment was received.

Before the substance of plaintiffs' complaint is considered, however, the defendants' challenge to this court's jurisdiction must be resolved. Because my jurisdictional ruling is dispositive, I do not rule on plaintiffs' substantive claims.

JURISDICTION

Federal courts are courts of limited jurisdiction. Subject matter jurisdiction must be established. Absence of jurisdiction is not waivable, Rule 12 (h)(3), Fed.R.Civ.P.

In the instant case plaintiffs, suing as private litigants, assert federal question jurisdiction based upon a violation of

rights they maintain are granted by federal statutes. Defendants deny jurisdiction because plaintiffs have been deprived of no right secured by the laws of the United States.

A private right of action is not the traditional means by which a state's noncompliance with a federal regulation is corrected. The ordinary remedy for noncompliance was for the federal government to cut off funding. A private action was permissible only if it were expressly or impliedly allowed by the underlying statute.

Recently, however, the Supreme Court in *Maine v. Thiboutot*, 448 U.S. 1 (1980), held that § 1983 actions may be used to redress deprivations of rights secured by federal statutory as well as constitutional law. Even if no private right of action exists under the substantive statute, § 1983 may still authorize a private suit.

However, a year after *Thiboutot*, the Court in *Middlesex County Sewerage Authority v. National Sea Calmmers* [*sic*], ___ U.S. ___, 101 S.Ct. 2615 (1981) the Court [*sic*] indicated that some distinction may exist between actions brought under § 1983 and a private right of action. In *Middlesex* the Court characterized § 1983 actions as "obviat[ing] the need to consider whether Congress intended to authorize private suits to enforce these particularly federal statutes." *Id.* at 2625.

Whatever may be the distinction between a § 1983 action and a private right of action, such is of no importance in the instant case because I consider both and find neither available.

42 U.S.C. § 1983 Actions

Section 1983 provides:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of the State of Territory, subjects or causes to be subjected, any

> citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), the Court construed § 1983 as authorizing private suits against state officials who violate rights created by federal statute.

On its face plaintiffs' claim appears to fall within *Thiboutot* as an action under § 1983 alleging state action violative of federal rights secured by Title XIX and DABRA. However, in the year and a half since *Thiboutot* the Court has recognized two important exceptions to the application of § 1983 to statutory violations.

In *Pennhurst State School and Hospital v. Halderman*, ___ U.S. ___, 101 S.Ct. 1531 (1981) and later in *Middlesex County Sewerage Authority v. National Sea Clammers*, ___ U.S. ___, 101 S.Ct. 2615 (1981) the Court held that a § 1983 is unavailable if:

> (1) Congress foreclosed private enforcement of a statute as a result of the remedy provided by [the] enactment itself.
>
> (2) the substantive statute did not create any enforceable "rights" under § 1983.

In *Pennhurst* the Court held that the underlying federal statute, the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6000 et. seq., did not create any substantive rights for the mentally retarded. Finding no conferral of rights, the Court avoided the question of whether a private cause of action was alternatively available.

Two months later in *Middlesex* the Court reiterated the *Pennhurst* exceptions, relying on the second exception that an exclusive statutory remedy within the substantive statute foreclosed any § 1983 claim. As a result, the Court did not

reach (as it had in *Pennhurst*) the question of whether any substantive rights were created.

Those decisions demonstrate that a § 1983 action will not succeed unless a private litigant establishes both a substantive right and the absence of an exclusive remedy within that statute. Plaintiffs' claim fails when subjected to those tests.

(1) *Statutory Creation of a Substantive Right,*

42 U.S.C. § 1983 creates no enforceable rights. *Maher v. Gagne*, 448 U.S. 122 (1980); *Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600 (1979); nor, inherently, does any federal statute. An enforceable right must be established by the terms of the underlying statute.

Whether enforceable rights were created by the statutes plaintiffs claim under is determined by *Pennhurst State School and Hospital v. Halderman*, ___ U.S. ___, 101 S.Ct. 1531 (1981). It is instructive for two reasons: First, its holding eliminates plaintiffs' claim under the Developmentally Disabled Assistance Act, leaving only Title XIX as a source of statutory rights. Second, the *Pennhurst* rationale refutes the argument that Title XIX creates enforceable rights.

Pennhurst shows that an examination of a statute's language structure and legislative history assists in determining when a right is created. *Id.* at 1540. In the instant case these indicate no enforceable rights were created by Title XIX.

Title XIX is basically a federal/state funding statute. Its language shows that its purpose is to assist the states in funding systems they develop and supervise. It says nothing of creating new, substantive rights for any individual or class. Its structure reflects administrative procedures and program requirements, not broad declarations of individual rights. Likewise, the legislative history does not indicate an intent to create rights. Thus no substantive rights were created under either statute.

(2) *Foreclosure of Private Enforcement*

A claim under § 1983 is also eliminated if the underlying statute provides for comprehensive remedial actions.

> "When the remedial devices provided in a particular act are sufficiently comprehensive, they may suffice to demonstrate Congressional intent to preclude the remedy of suits under § 1983."

Middlesex, supra, at 2626.

An examination of the "remedial devices" contained in Title XIX (the Developmentally Disabled Assistance Act having been eliminated as a source of rights by the *Pennhurst* decision) reveals an obvious rejection of judicial involvement. The statute provides for the termination of funding as the means of redress. There is no authorizaton of a private suit.

Judicial intervention is particularly inappropriate since compliance is monitored administratively at both the federal and state level. The program's structure requires long-range planning, periodic evaluation and swift enforcement—functions for which litigation is ill-suited. Given the history and structure of the congressional scheme, it is doubtful that Congress intended judicial intervention (particularly at the behest of a private litigant) as the means of redress.

Plaintiffs can not [*sic*] maintain a § 1983 action in the instant case based upon an alleged violation of their equal protection rights. The mentally retarded do not constitute a suspect class so as to trigger strict scrutiny under the Fourteenth Amendment. The applicable constitutional standard under the equal protection clause is whether the challenged state action rationally furthers a legitimate state purpose or interest. *San Antonio Indepedent* [*sic*] *School District v. Rodriquez*, 411 US. 1 (1973); *McGinnis v. Royster*, 410 U.S. 263 (1973). While the policy decision underlying Oregon's Model Budget Plan may be questioned, it cannot be said that the

plan is irrational nor that it is not intended to further legitimate state interest.

Private Right of Action

I find no private right of action, either express or implied, to be available to the plaintiffs under the following analysis.

(1) *Express Private Right of Action*

Plaintiffs can not [*sic*] claim an express right of action under either Title XIX or the Developmentally Disabled Assistance Act. Neither contains an express authorization of a private suit. The procedures and sanctions provided to ensure compliance do not include litigation. Disapproval of a state's plan or the termination of funds are stated remedies. No other cause of action is recognized.

(2) *Implied Private Right of Action*

In *Cort v. Ash*, 422 U.S. 66 (1975), the Supreme Court set forth four criteria for determining if a statute implied a private right of action:

> First: Is the plaintiff "one of the class for whose benefit the statute was enacted?"
>
> Second: Is there any indication of legislative intent, explicit or implicit, either to create or deny such a remedy?
>
> Third: Is it consistent with the underlying purposes of the legislative scheme to imply a remedy?
>
> Fourth: Is the cause of action one traditionally relegated to state law, in an area basically the concern of the states, so that it would be inappropriate to infer a cause of action based solely on federal law?

Applying these criteria, I find no implied private right of action for the following reasons:

> (1) While plaintiffs are within the "class" for whose benefit the statutes were enacted, any right must conform to the legislative intent and scheme. As the Court noted in *California v. Sierra Club*, ___U.S. ___, 101 S.Ct. 1775, 1779 (1981), "The question is not

simply who would benefit from the Act, but whether Congress intended to confer federal rights upon those beneficiaries.["] *Pennhurst* states that no conferral of rights was intended within the Developmentally Disabled Assistance Act, as does an analysis of Title XIX (see above).

(2) Legislative intent can be gleaned from the legislative history or statutory language. Here the legislative history is silent. Similarly, the statutory language shows that administrative rather than judicial enforcement is anticipated. Under Title XIX the state bears the responsibility of developing the program, of determining eligibility and of insuring that "care and services" will be provided "in the best interest of the recipients," 42 U.S.C. § 1396a (a)(17)(19), with no provision for federal judicial review.

(3) While the "underlying purpose" of both statutes is to benefit individuals, it does so indirectly, through financial assistance to states who choose to participate. While imposing certain federal standards, the intent is to minimize federal involvement by giving the states the administrative responsibility. To imply a private cause of action would be contrary to that intent. As Judge Krupansky observed in *Fuzio v. Manor Care, Inc.*, 461 F.Supp. 689, 697 (1977):

"A private right of action, utilized to enforce specific, limited portions of federal regulations on an ad hoc basis, would circumvent the responsibility of the state to administer its plan on [*sic*] an organized manner 'consistent with simplicity of administration and the best interests of the recipients,' 42 U.S.C. § 1396(a)(19), transferring the primary obligation in such cases from the administrative personnel intended to bear it to the federal courts."

(4) Plaintiffs challenge the state's policy decision as to the allocation of its resources. This is not an area amenable to judicial intervention. It involves a subject within the dominion of the state, traditionally relegated to state law. A state is free to budget funds

according to its priorities unless it violates individual rights. Any objection to a state's decision is best left to state officials.

Upon consideration of the above factors, I conclude that no implied right to private action exists. This is in keeping with the decisions of the Ninth Circuit, including the recent decision in *Community Psychiatric Centers of Oregon, Inc. v. Grant*, 664 F.2d 1148 (9th Cir. 1981).

CONCLUSION

The structure of this litigation and the alignment of the parties complicated this case. While residents of Siuslaw are ostensibly the plaintiffs, in reality the beneficiary would be the facility in which they reside. The rights plaintiffs claim are not theirs to assert.

Plaintiffs do not sue for the denial of a direct payment due them, as in *Thiboutot*, nor do they allege unsanitary conditions threatening their well-being, as in *Pennhurst*.

Instead, they challenge the reimbursement system which compensates the facility for their care while simultaneously acknowledging that facility's compliance with all federal and state standards.

This challenge is based, however, on rights not given them by law. I find that neither Title XIX nor the Developmentally Disabled Assistance and Bill of Rights Acts confers rights enforceable in this court. While those laws are directed at improving plaintiffs' condition, they set goals rather than create rights. Without such rights there is no federal question and thus this court has no jurisdiction.

Those goals seek to normalize the lives of the mentally retarded and to do so in the least restrictive environment. The intent is definite and admirable. But beyond legislative intent lies the task of program development and implementation.

Having articulated its standards and goals, Congress left to the states the task of designing an effective means of accomplishing them. Each state acts within the limits of its own budget and allocates its resources as it sees fit. Some will be more successful than others. Our system of government fosters that experimentation and views as beneficial the diversity inherent in a federal system.

In reviewing Oregon's response, this court must not impose its personal standards or beliefs. Only if the plan transgressed the law or violated constitutional rights should it be set aside. I find that such is not the case. It is uncontested that Siuslaw was in full compliance both before and after the imposition of the Model Budget Plan. Plaintiffs' own witnesses so testified. This is buttressed by the federal government's review and approval of the Model Budget Plan.

Before trial defendants submitted a motion to dismiss which was deferred until after a trial to the court, in which both sides presented evidence. Having reviewed that evidence and the arguments articulated by counsel's briefs, I find that for the above reasons this court lacks jurisdiction over plaintiffs' claims and I therefore grant defendants' motion to dismiss.

It is so ORDERED.

DATED this 16 day of April, 1982.

[signature omitted in printing]

[1] The Supreme Court held that the Developmentally Disabled Assistance and Bill of Rights Act did not create any substantive rights to "appropriate treatment" in the "least restrictive" environment for the mentally retarded. *Pennhurst* at pp. 1536-1547.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OREGON

[List of attorneys omitted in printing]

COOS BAY CARE CENTER, an Oregon corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,	)	Case No. _____
Plaintiffs,	)	COMPLAINT FOR BREACH OF CONTRACT; VIOLATION OF FEDERAL CONSTITUTION AND STATUTES; CLASS ACTION AND DEMAND FOR JURY TRIAL
vs.	)	
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	)	
Defendants.	)	

COME NOW, Plaintiffs, by and through their attorneys of record, PARKINSON, LOJEK & PENLAND, CHARTERED, and HARLAND, RITTER, SAALFELD & GRIGGS, and for their cause of action against the Defendants, complain and allege as follows:

1. Plaintiff, Coos Bay Care Center, Inc., is an Oregon corporation with its principal place of business in Coos Bay, County of Coos, Oregon.

2. The named Plaintiffs are Hanna Schwanke and Sandy Mauer, Guardians Ad Litem, respectively, for David and Steven Schwanke and Tami Mauer, who are heavy care patients at the Coos Bay Care Center, Coos Bay, Oregon. All named Plaintiffs are Oregon residents.

3. Title XIX of the Social Security Act, as amended, commonly known as "Medicaid," provides for medical assistance to the indigent and developmentally disabled in the form of a cooperative program between each of the participating states and the United States of America.

4. Defendant, Department of Human Resources, pursuant to Oregon Revised Statutes 184.750 and 441.060, is an agency of the State of Oregon and is responsible for administering the Title XIX medical assistance program within the State of Oregon.

5. Defendant, Richard C. Ladd, is the person responsible for the administration of the State of Oregon, Department of Human Resources, and, at all material times hereto, has acted under color of state law.

6. The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1331. The Plaintiffs' claims arising under Oregon law as more particularly stated herein are within the pendent jurisdiction of the Court since they arise out of a common nucleus of facts with the federal claims presented herein and are of such a nature that the Plaintiffs would ordinarily be expected to try all such claims in one proceeding.

7. Coos Bay Care Center, Inc. is engaged in the principal business of providing long-term care to the developmentally disabled and to the aged.

8. Coos Bay Care Center, Inc. is a licensed Intermediate Care Facility under the laws of the State of Oregon and has been so licensed at all material times hereto.

9. Coos Bay Care Center, Inc. on the 5th day of May, 1982, entered into an agreement with the Defendant State of Oregon, Department of Human Resources, Senior Services Division, for providing care under the Oregon Title XIX medical assistance program as an Intermediate Care Facility. A copy of the aforesaid agreement between Plaintiff, Coos Bay Care Center, Inc., and the Defendants is attached to this Complaint as Exhibit "A".

10. Plaintiffs David and Steven Schwanke and Tami Mauer are third party beneficiaries of this agreement and may maintain an action upon it.

11. The aforesaid agreement, *inter alia*, compels Coos Bay Care Center, Inc., (provider) and the Defendants to comply with applicable federal regulations as more particularly set forth at 42 C.F.R. § 442.300 and 42 C.F.R. § 442.250 and other regulations, as adopted.

12. The aforesaid agreement further obligates the Defendants to make payments to the provider in accordance with all federal and Oregon Administrative Rules applicable to Intermediate Care Facilities under the Title XIX Long-Term Care Facility Services Program existing within the State of Oregon.

13. The Title XIX program is established by the Social Security Act, as amended, 42 U.S.C. § 1396a *et seq.* and Oregon has chosen to participate therein. This program makes the State of Oregon responsible for the administration of state funds and the federal contribution under Title XIX of the Social Security Act, as amended.

14. Oregon has established a Medical Assistance Program (Medicaid) within the State which compels compliance with the State's own statutory terms and conditions thereof as well as all applicable regulations promulgated by the Department of Health and Human Services of the United States of America.

15. 42 U.S.C. § 1396a(a)(13)(A), particularly, provides that the state plan adopted by each state must contain

assurances satisfactory to the Secretary of the Department of Health & Human Services that established rates of reimbursement to participating medicaid providers are determined in accordance with methods and standards developed by the state and are reasonable and adequate to meet the costs which must be incurred by those providers who are efficiently and economically operated as they provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

16. Further, 42 C.F.R. § 447.252(a) provides that the single state agency responsible for administering the medicaid program within that state must pay for long term care rendered under the medical assistance program at a level which is sufficient to meet the costs which must be incurred by an efficiently and economically operated long term health care facility.

17. Additionally, § 411-70-030, of the Department of Human Resources, Senior Services Division, Nursing Facility Services Guide for Title XIX Medical Assistance Programs, provides, *inter alia*, for specific and complete reimbursement for provision of heavy cost care.

18. "Heavy care" patients are those who, by virtue of their medical or developmental problems, require significantly more or greater care than does the ordinary intermediate patient.

19. The heavy cost rates must include and reimburse for all nursing staff services, food or food substitutes, dressings, catheters and other special supplies as detailed in Rules 411-70-085 and 411-70-090.

20. The heavy cost rate does not include certain medical services as stated in Regulation 411-70-030(7)(a). Heavy cost care patients may be eligible under this rule and covered by rates for reimbursement in accordance with the rule.

21. There are now and have for some time been a number of patients at the Coos Bay Care Center, and at other similar

institutions within the State of Oregon, who are eligible for heavy cost care.

22. Patients at Coos Bay Care Center have been duly certified by physicians who have executed a Heavy Care Assessment and who have certified that the needs of the patient conform to the aforesaid rules and regulations of the Senior Services Division of the Department of Human Resources, State of Oregon.

23. In spite of the qualification of the patients, the State of Oregon and Defendant Richard C. Ladd, acting under color of state law, have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients to and on behalf of the Plaintiffs, thus denying them due process of law guaranteed by the Fifth and Fourteenth Amendments to the Constitution of the United States of America and resulting in a taking of property for public use without just compensation. Accordingly, the Plaintiffs' wards, David and Steven Schwanke and Tami Mauer, and the class they represent do not receive the quantity or quality of care guaranteed to them constitutionally and by state and federal laws, statutes and regulations as aforesaid, although Plaintiff Coos Bay Care Center does afford "heavy care" patients as much "heavy care" as possible.

24. Throughout the State of Oregon there are other heavy care patients residing within long-term health care facilities who similarly qualify for heavy care but who do not recieve the full amount of appropriate care because of the refusal of the Defendants to appropriately reimburse health care providers for such care.

CLASS ACTION ALLEGATIONS

25. Plaintiffs therefore bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedure on their own behalf and on behalf of all other residents of licensed long term health care facilities within the State of Oregon who, as a

result of Defendants' actions, or non-action, have not been granted full medical assistance commensurate with their status as heavy care patients as more particularly described below.

26. The number of heavy care patients in the Plaintiff class is so numerous that the joinder of all members of the class is impracticable. Upon information and belief, the named Plaintiffs aver that the number of heavy care patients in the proposed class exceeds 100 patients, statewide.

27. The claims of the representative Plaintiffs are typical of the Plaintiff class and arise out of identical facts constituting the unlawful conduct of the Defendants. The representative Plaintiffs will fairly and adequately protect the interests of the Plaintiff class.

28. This action may be maintained as a class action pursuant to Rule 23(a)(2) of the Federal Rules of Civil Procedure since Defendants have acted and refuse to act on grounds generally applicable to the Plaintiff class, thereby making appropriate final declaratory relief with respect to the class as a whole.

29. This action may be maintained as a class action pursuant to Rule 23(b)(3) of the Federal Rules of Civil Procedure since the questions of law and fact common to the claims of the Plaintiff class and resulting from Defendants' actions predominate over any questions affecting only individual members. The successful assertion of the claims of the named Plaintiffs necessarily establish determinations of fact and law adequate to prove the unlawful actions of Defendants, thereby making a class action superior to any other available method for the fair and efficient adjudication of the claims of the named Plaintiff class.

FIRST CAUSE OF ACTION

30. Plaintiffs hereby incorporate and reallege paragraphs 1 through 29 in this paragraph as if fully set forth herein.

31. The aforesaid course of conduct by the Defendants violates 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252.

32. As a direct and proximate result of the violation of these statutes and regulations the Plaintiffs have been damaged in the approximate amount of $138,600.00 and will continue to be irreparably damaged in the amount of the differential between the heavy cost care afforded and routine care.

SECOND CAUSE OF ACTION

33. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

34. The aforesaid course of conduct by the Defendants constitutes a breach of contract by the Defendants.

35. As a proximate result of this breach of contract the Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and will continue to be damaged on a daily basis. Plaintiffs Schwanke and Mauer and the class they represent will continue not to be afforded the full measure of heavy cost care to which they are entitled.

THIRD CAUSE OF ACTION

36. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

37. The aforesaid course of conduct by the individual Defendants constitutes a violation of 42 U.S.C. § 1983 in depriving the Plaintiffs of their constitutional rights under the Fourteenth Amendment of the United States Constitution and their statutory rights, both state and federal, as aforesaid.

38. As a proximate result of the violation of Plaintiffs' constitutional rights, Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and Plaintiffs Mauer, Schwanke and each member of the class they represent have been damaged in the amount of $10,000.00.

39. Plaintiffs hereby claim all necessary and proper attorney's fees in accordance with 42 U.S.C. § 1988.

WHEREFORE, Plaintiffs pray for relief as follows:

1. For a declaratory judgment of this Court that those medicaid patients in Oregon long term health care facilities who are certified as heavy care patients be recognized as such by the State of Oregon in accordance with the rules and regulations of the State of Oregon and the United States, Department of Health & Human Services, and that those long-term health care facilities who provide care to such patients be reimbursed appropriately.

2. For a further order from this Court to direct the Defendants to conform to the aforesaid Federal statutes and regulations in their reimbursement methodology in the administration of the Medicaid program.

3. For a further declaratory judgment that the agreement between Plaintiff Coos Bay Care Center and the State of Oregon has been breached by the State and that the Plaintiffs have been and are being damaged thereby.

4. For an injunction prohibiting the Defendants from violating federal and state law, as alleged.

5. For damages pursuant to 42 U.S.C. § 1983, in the amount of $138,600.00 to Plaintiff Coos Bay Care Center which represents the lack of appropriate reimbursement from May 26, 1982, to the date of judgment, and for an award of $10,000.00 each to the other named Plaintiffs and to each member of the class they represent.

6. For Plaintiffs' attorney's fees, costs and expenses reasonably incurred in bringing this cause of action pursuant to 42 U.S.C. § 1988 and the Federal Rules of Civil Procedure.

7. For such other and further relief as to this Court seems just.

Dated this 27th day of April, 1984.

[Signatures omitted in printing]

APPENDIX F

Heavy Cost Care

411-70-030 (1) Resident Eligibility: To be eligible for payment under the Heavy Cost Program, the resident must:

(a) Meet the definition of functional quadriplegia (see subsection (2)(b) of this rule);

(b) Be a person ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital (see subsection (3)(d) of this rule);

(c) Have prior approval of the local Division or Type B Area Agency on Aging Pre-Admission Screening Team Registered Nurse (see subsection (6)(a) of this rule).

. . . .

(7) Rates:

(a) The heavy cost rate will include all nursing staff services, food or food substitutes, dressings, catheters and other special supplies, as detailed in rules 411-70-085 and 411-70-090. The heavy cost rate does not include those medical services, i.e., physician, physical therapy, pharmacy, dental, etc., paid through Title XIX, Title XVIII, Veterans Administration, etc., and personal incidental items authorized for payment from the client's personal incidental allowance. (See rule 411-70-095)

(b) The amount of the heavy cost rate will be on add-on to the facility's established rate for the client's level of care.

APPENDIX G

All-Inclusive Rate

411-70-085 (1) The skilled and/or semi-skilled rate established for a facility includes all services, supplies, and facility equipment required for care. This rule *does not apply to*: medical care services by outside providers paid through Title XIX Medical Assistance funds, Title XVIII, VA, etc.; and personal incidental items authorized for payment from the client's personal incidental allowance.

(2) The following types of items and services are included in the all-inclusive rate (the fact that the provider may customarily make a separate charge to private residents is irrelevant):

(a) All nursing and supportive care services including restorative nursing care.

(b) Room, board, and laundry (including laundry of residents' bedding and clothing whether performed by the facility or an outside provider).

(c) Items which are routinely furnished to all residents without additional cost.

(d) Items stocked by the facility in gross supply and administered individually on physician's order.

(e) Items owned or rented by the facility which are utilized by individual residents but which are reusable and expected to be available in a nursing facility.

(f) Non-legend, over-the-counter pharmaceuticals *not* listed in the basic drug formularies in Adult and Family Services Division's **"Guide for Pharmaceutical Services"**. (See rule 411-70-090, Payment for Medical Care and Services, section (1).)

(g) Shaves, haircuts, and shampoos as required regularly for grooming and cleanliness must be provided by the facility. These are included in the all-inclusive rate whether performed by facility staff or outside providers.

APPENDIX H

Rate Setting Per Diem Rate

411-70-440 (1) The maximum per diem rates for skilled nursing facilities and intermediate care facilities will be established by the Division effective January 1 of each year. The rates will be based on financial statements received by the Division by September 30 which cover fiscal periods ending in the last full fiscal year of the Division (July 1 through June 30). The financial statements will be desk reviewed or audited by the Division and the resulting total allowable per diem costs for each type of facility will be arrayed in rank order from the lowest total per diem cost to the highest total per diem cost. A similar array of total allowable indirect per diem costs including both types of facilities will be established.

(2) The Division has established the 75th percentile ranking from lowest to highest total allowable per diem costs as the maximum per diem rate needed to reimburse an efficiently and economically operated facility. The Division has also established the 75th percentile ranking from the lowest to the highest total allowable indirect per diem costs as the maximum indirect per diem rate.

APPENDIX I

Definitions

461-09-000 (1) Whenever used in this Division, or in any amendment or supplement thereto, unless otherwise specified, the following terms shall have the meanings herein stated:

(1) A "claimant" is a person:

(a) Seeking an opportunity to sign an application for public assistance;

(b) Who has applied and is awaiting the agency's decision on that application;

(c) Whose application has been approved;

(d) Receiving assistance or whose assistance payment has been reduced, suspended, discontinued or the manner of payment is changed to a protective, vendor or two-party payment;

(e) Still considering himself/herself entitled to assistance;

(f) Who is aggrieved by any other agency action affecting his/her receipt or termination of assistance;

(g) Who was denied or excluded from an AFS service program.

(2) A "contested case" is a case in which:

(a) A constitutional provision or an agency enabling act requires a hearing upon the action; or

(b) The agency has discretion to suspend; or

(c) There is a proceeding in which the agency by rule or order provides for a hearing, in accordance with contested case requirements.

(3) A "hearing" is an informal contested case proceeding before an impartial hearings official appointed by AFS. The claimant of public assistance or his/her representative may present all pertinent facts and evidence to show why action or inaction in his/her case should be reconsidered by AFS.

(4) A "request for a hearing" is a written expression received by the Division within 30 days from the date of notice on an Administrative Hearing Request form completed by the claimant or by any person acting in his/her behalf, describing the agency action or issue he/she desires to contest.

(5) The "date of the request" is:

(a) The date the completed and signed Administrative Hearing Request form is received in the AFS branch office; or

(b) The date the first oral or written request was received in the AFS branch office provided:

(A) The claimant or his/her representative complete and sign an Administrative Hearing Request form; and

(B) The Administrative Hearing Request form is received in the AFS branch office within fifteen (15) calendar days from the date of notice.

(6) "Handicap" is a physical or mental impairment which substantially limits one or more major life activities, a record of such impairment, or the state of being regarded as having such an impairment.

The Hearing Request

461-09-010 (1) Any claimant of public assistance or service payments has the right to request a hearing in relation to any action on his/her claim or failure to act on his/her claim by a branch office/unit/agency at any time. Only the Chief Hearing Officer can dismiss the request as specified in rule 461-09-060.

(2) A hearing may be requested at any time prior to written notice where the branch office/unit/agency has failed to act on a claim.

(3) A request for a hearing is not complete until the Administrative Hearing Request form is completed and signed by the claimant or the claimant's representative, and received by the branch office/unit/agency.

(4) The applicant for public assistance has the right to request a hearing if after 45 days there has been no formal action on his/her application.

(5) Any person who has a handicap has the right to request a hearing when he/she feels he/she has been wrongfully denied benefits or services, or has been otherwise subjected to discrimination because of the handicap.

(6) Every request for a hearing shall be given prompt attention to assure that definite and final administrative action is taken. The Hearings Unit shall immediately acknowledge, in writing, the receipt of an Administrative Hearing Request form to both the claimant and to the branch office/unit/agency. The acknowledgement to the claimant shall describe the procedure followed in hearings. The branch office/unit/agency may, at any time, reconsider its decision in the light of current circumstances, and advise the claimant of any change in its decision.

Group Fair Hearings

461-09-011 The Hearings Unit may respond to a series of individual requests for hearings by conducting a single group hearing. Hearings may be so consolidated in cases when the sole issue is a Division policy. If recipients request a group hearing, the Hearings Unit will grant it. Each individual has the right to withdraw from the group hearing in favor of an individual hearing.

Appeals

411-70-435 A certified letter will be sent notifying the provider of the year-end settlement. The provider shall notify the Division in writing within 15 days of receipt of the letter if the provider wishes to appeal the settlement. Letters must be postmarked within the 15-day limit.

APPENDIX J

183.482 Jurisdiction for review of contested cases; procedure; scope of court authority. (1) Jurisdiction for judicial review of contested cases is conferred upon the Court of Appeals. Proceedings for review shall be instituted by filing a petition in the Court of Appeals. The petition shall be filed within 60 days only following the date the order upon which the petition is based is served unless otherwise provided by statute. If a petition for rehearing has been filed, then the petition for review shall be filed within 60 days only following the date the order denying the petition for rehearing is served. If the agency does not otherwise act, a petition for rehearing or reconsideration shall be deemed denied the 60th day following the date the petition was filed, and in such cases, petition for judicial review shall be filed within 60 days only following such date. Date of service shall be the date on which the agency delivered or mailed its order in accordance with ORS 183.470.

(2) The petition shall state the nature of the order the petitioner desires reviewed, and shall state whether the petitioner was a party to the administrative proceeding, was denied status as a party or is seeking judicial review as a person adversely affected or aggrieved by the agency order. In the latter case, the petitioner shall, by supporting affidavit, state the facts showing how the petitioner is adversely affected or aggrieved by the agency order. Before deciding the issues raised by the petition for review, the Court of Appeals shall decide, from facts set forth in the affidavit, whether or not the petitioner is entitled to petition as an adversely affected or an aggrieved person. Copies of the petition shall be served by registered or certified mail upon the agency, and all other parties of record in the agency proceeding.

(3)(a) The filing of the petition shall not stay enforcement of the agency order, but the agency may do so upon a showing of:

(A) Irreparable injury to the petitioner; and

(B) A colorable claim of error in the order.

(b) When a petitioner makes the showing required by paragraph (a) of this subsection, the agency shall grant the stay unless the agency determines that substantial public harm will result if the order is stayed. If the agency denies the stay, the denial shall be in writing and shall specifically state the substantial public harm that would result from the granting of the stay.

(c) When the agency grants a stay it may impose such reasonable conditions as the giving of a bond or other undertaking and that the petitioner file all documents necessary to bring the matter to issue before the Court of Appeals within specified reasonable periods of time.

(d) Agency denial of a motion for stay is subject to review by the Court of Appeals under such rules as the court may establish.

(4) Within 30 days after service of the petition, or within such further time as the court may allow, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review, but, by stipulation of all parties to the review proceeding, the record may be shortened. Any party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record when deemed desirable. Except as specifically provided in this subsection, the cost of the record shall not be taxed to the petitioner or any intervening party. However, the court may tax such costs and the cost of agency transcription of record to a party filing a frivolous petition for review.

(5) If, on review of a contested case, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the

court that the additional evidence is material and that there were good and substantial reasons for failure to present it in the proceeding before the agency, the court may order that the additional evidence be taken before the agency upon such conditions as the court deems proper. The agency may modify its findings and order by reason of the additional evidence and shall, within a time to be fixed by the court, file with the reviewing court, to become a part of the record, the additional evidence, together with any modifications or new findings or orders, or its certificate that it elects to stand on its original findings and order, as the case may be.

(6) At any time subsequent to the filing of the petition for review and prior to the date set for hearing the agency may withdraw its order for purposes of reconsideration. If an agency withdraws an order for purposes of reconsideration, it shall, within such time as the court may allow, affirm, modify or reverse its order. If the petitioner is dissatisfied with the agency action after withdrawal for purposes of reconsideration, the petitioner may file an amended petition for review and the review shall proceed upon the revised order. If an agency withdraws an order for purposes of reconsideration and modifies or reverses the order in favor of the petitioner, the court shall allow the petitioner costs, but not attorney fees, to be paid from funds available to the agency.

(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. In the case of disputed allegations of irregularities in procedure before the agency not shown in the record which, if proved, would warrant reversal or remand, the Court of Appeals may refer the allegations to a Master appointed by the court to take evidence and make findings of fact upon them. The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the

action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

(A) Set aside or modify the order; or

(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

(A) Outside the range of discretion delegated to the agency by law;

(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

(C) Otherwise in violation of a constitutional or statutory provision.

(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding.

183.484 Jurisdiction for review of orders other than contested cases; procedure; scope of court authority. (1) Jurisdiction for judicial review of orders other than contested cases is conferred upon the Circuit Court for Marion County and upon the circuit court for the county in which the petitioner resides or has a principal business office. Proceedings for review under this section shall be instituted by filing a petition in the Circuit Court for Marion County or the circuit court for the county in which the petitioner resides or has a principal business office.

(2) Petitions for review shall be filed within 60 days only following the date the order is served, or if a petition for reconsideration or rehearing has been filed, then within 60 days only following the date the order denying such petition is served. If the agency does not otherwise act, a petition for rehearing or reconsideration shall be deemed denied the 60th day following the date the petition was filed, and in such case petition for judicial review shall be filed within 60 days only following such date. Date of service shall be the date on which the agency delivered or mailed its order in accordance with ORS 183.470.

(3) The petition shall state the nature of the petitioner's interest, the facts showing how the petitioner is adversely affected or aggrieved by the agency order and the ground or grounds upon which the petitioner contends the order should be reversed or remanded. The review shall proceed and be conducted by the court without a jury.

(4)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

(A) Set aside or modify the order; or

(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

(A) Outside the range of discretion delegated to the agency by law;

(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

(C) Otherwise in violation of a constitutional or statutory provision.

(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding.

(5) In the case of reversal the court shall make special findings of fact based upon the evidence in the record and conclusions of law indicating clearly all aspects in which the agency's order is erroneous.

Supreme Court, U.S.
FILED
APR 10 1987
JOSEPH F. SPANIOL, JR.
CLERK

(2)

No. 86-1419

In The
Supreme Court of the United States
October Term, 1986

State of Oregon, Department of Human Resources; Richard Ladd,

Petitioners,

v.

Coos Bay Care Center, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

BRIEF IN OPPOSITION TO CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

Petitioners' Statement of Questions Presented is not entirely precise. The questions, more accurately put, are as follows:

1. May states which participate in Title XIX wilfully violate the federal Constitution, federal statutes and federal regulations while accepting billions of dollars in federal matching funds, and then be immune from federal judicial oversight?

2. If not, then is 42 U.S.C. § 1983 an appropriate statute to insure uniform interpretation of Title XIX of the Social Security Act?

3. Who can bring a claim challenging a state's gross and wilful violations of the mandates of Title XIX?

LIST OF PARTIES

The parties are accurately listed in the caption of the case.

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United States Alkai Export Association v. United States, 325 U.S. 196, 65 S.Ct. 1120, 89 L.Ed. 2d 1554 (1945) 18

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No. 86-1419

In The

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State of Oregon, Department of Human Resources; Richard Ladd,

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Coos Bay Care Center, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

BRIEF IN OPPOSITION TO CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit may be found in Petitioner's Appendix commencing at App-1. The opinion of the United States District Court for the District of Oregon may be found in Petitioner's Appendix commencing at App-7. The opinion of the United States Magistrate similarly may be found in Petitioners' Appendix commencing at App-9.

STATUTES INVOLVED

The statutes and regulations involved in this case include those identified by Petitioners and 42 U.S.C. §§ 1983 and 1988.

STATEMENT OF THE CASE

Petitioners' Statement is too narrow in overlooking that plaintiffs' complaint alleges plaintiffs David and Steven Schwanke and Tami Mauer, quadriplegic patients of the Coos Bay Care Center, have been deprived of that quantity or quality of care to which they are entitled constitutionally *and* by state and federal laws, statutes, and regulations. Oregon, acting through its administrator, Mr. Ladd, has chosen to participate in Title XIX of the Social Security Act. Federal Medicaid funds in the millions of dollars are accepted by the state and distributed by Mr. Ladd. Yet, Oregon and its administrator refuse to conform to the governing federal scheme as set out at 42 U.S.C. §§ 1396 *et seq.* and in regulations promulgated thereunder by the Secretary of the Department of Health and Human Services.

Petitioners' Statement also is unfortunately inaccurate where they state, at p. 6, that plaintiffs have not alleged a violation of federal law. On the contrary, plaintiffs, in paragraphs 13, 14, 15, 31, and 37 of their complaint (App-33, 37) allege that the Oregon Medicaid State Plan and the State's conduct under Title XIX are in violation not only of the Constitution, but also 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252.

Finally, it should be noted that a Motion to Dismiss was filed before any discovery took place. The Magistrate's Opinion indicates an unwillingness to "overrule" an unpublished 1982 decision authored by the U.S. District Court, District of Oregon in *Beecroft v. Atiyeh*, No. 78-1027-BU (D.Or. April 16, 1982) (App-12). That dismissal was appealed to the same District Judge who had authored

Beecroft, supra. The District Court affirmed the Magistrate in a terse opinion found at App-7, essentially affirming himself on the basis of his decision in *Beecroft* which is found at App-17. That decision involves the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6000 *et seq.*—a statute not involved in any way with this case.

Plaintiffs then appealed to the Ninth Circuit Court of Appeals which held, *inter alia,* that "Medicaid patients and health-care providers have parallel interests" and may stand as co-plaintiffs. (App-5). From that decision the Petitioners have come before this Court.

SUMMARY OF ARGUMENT

1. The Petitioners have not identified the types of reasons for granting a petition for writ of certiorari as contemplated by the Rules of this Court. Specifically, Title XIX creates rights which may be enforced through 42 U.S.C. § 1983. The states cannot, on the one hand, accept billions of Medicaid dollars, and then on the other, flagrantly violate the Constitution and the federal laws creating and implementing Title XIX without the scrutiny of federal courts, as they argue. Nor are plaintiffs required to exhaust state remedies which are, as here, clearly futile.

2. There is no split of authority among the Circuit Courts of Appeal on any issue presented here.

ARGUMENT

I. THERE ARE NO SPECIAL OR IMPORTANT REASONS FOR THIS COURT TO GRANT CERTIORARI

A. The Decision Below Considered the Relevant Issues and Correctly Decided Them.

The Petitioners have somehow misconstrued Respondents' causes of action, and badly at that. The Petitioners state at p. 6 of their brief: "Plaintiffs' complaint did not claim that Oregon's Medicaid plan itself violates federal law." Yet, we find clearly stated in the complaint allegations at paragraphs 13, 14, and 15 that the "State Plan" adopted by each state participating in the Title XIX program must meet certain *federal* requirements. Then, at paragraph 31, Respondents allege a failure of the State Plan (or State conduct) to comply with *federal* law. Nothing could be plainer. (App-33, 37).

Petitioners have also conveniently overlooked the guardians ad litem who seek to bring this action on behalf of three named individuals who are functional quadriplegics and who reside at the Coos Bay Care Center. More precisely, the case is brought for the named individuals and for the class they represent. (App-35, 36). Yet, like the Attican giant, Procrustes, Petitioners measure plaintiffs' complaint on their iron bed and lop off whatever does not fit their theories of this action. At least one-half of this case has not even been addressed in Petitioners' Petition.

Further, Respondents allege a deprivation of constitutional rights *and* their federal statutory rights at paragraph 37 of their complaint. Since the trial court granted

a Rule 12(b) Motion to Dismiss, the allegations of plaintiffs' complaint must be regarded as true. *See, e.g., Hughes v. Rowe,* 449 U.S. 5 (1980). Therefore, it must clearly be seen that Petitioners seek by their brief to ask this Court to deny access to the federal courts when federal statutes, federal regulations, and the federal Constitution have been violated by a state official acting under color of state law. Given this set of facts, it is understandable why Petitioners and their *amici* would prefer the benign comfort of their own "remedies" while avoiding the more rigorous climate which will usually be found in a federal court which interprets federal law.

Medicaid is indeed a joint federal/state enterprise, and a large one at that.[1] Providers of health care services are solicited by the states to participate in rendering care to those indigent persons who are eligible. The providers come forward and commit their resources, both human and capital, towards implementing the spirit and intent of a federal statute (42 U.S.C. § 1396a *et seq.*) made more clear, more specific, by hundreds and hundreds of federal regulations. (*See,* generally 42 C.F.R.) While states have some flexibility in their implementation of their individual Medicaid programs, each state, like it or not, is tethered to the federal requirements beyond which they may not go. *Harris v. McRae,* 448 U.S. 297, 103 S.Ct. 683 (1980). There is a responsibility which comes with the federal match and

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[1]Under current law, federal and state governments are expected to spend $25.9 billion and $21.3 billion respectively in 1987 to finance health care for indigent Americans. Office of Management and Budget, Executive Office of the President, Budget of the United States Government, at 5-102 (Fiscal Year 1987).

when there is a question as to whether that state responsibility has been entirely violated, can the states be heard to say that the federal courts are powerless to decide the question? Apparently they would like to confuse sovereignty with license; they refuse to accept the rather clear instruction from the Court in *Maine v. Thiboutot*, 448 U.S. 1 (1980) and, most recently, in *Wright v. City of Roanoke Redevelopment and Housing Authority*, — U.S. —, 107 S.Ct. 766 (1987).

The task of the Ninth Circuit Court of Appeals in rendering the decision below was a relatively simple one. All it was required to do was follow well-established and clear principles set forth by this Court. Taking the allegations of the complaint as true, the issue was simply whether 42 U.S.C. § 1983 and its "and laws" provision gives rise to a private right of action in connection with alleged violations by the state of Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1982 & Supp. III 1985), and the implementing federal and state regulations. The Court of Appeals answered in the affirmative. The task was relatively simple because this Court had in *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 2054, 65 L.Ed.2d 555 (1980), held that 42 U.S.C. § 1983 does provide a basis for actions to compel participating states to comply with provisions of the Social Security Act, of which the "Medicaid" statute in question here is a part.

Actually, the *Maine v. Thiboutot* decision is part of an unbroken chain of decisions finding § 1983 available as a vehicle to enforce various provisions of the Social Security Act. In support of its conclusion that "suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the participat-

ing states," *Maine v. Thiboutot, supra,* 448 U.S. at 4, *quoting Rosado v. Wyman,* 397 U.S. 397 (1970), the Court noted:

> While some might dismiss as dictum the foregoing statements, numerous and specific as they are, our analysis in several § 1983 cases involving Social Security Act (SSA) claims has relied on the availability of a § 1983 cause of action for statutory claims. . . . *Miller v. Youakim,* 440 U.S. 125, 132, and n. 13, 99 S.Ct. 957, 963, 59 L.Ed.2d 194 (1979) (state foster care program inconsistent with SSA); *Quern v. Mandley,* 436 U.S. 725, 729, and n. 3, 98 S.Ct. 2068, 2072, 56 L.Ed.2d 658 (1978) (state emergency assistance program inconsistent with SSA); *VanLare v. Hurley,* 421 U.S. 338, 95 S.Ct. 1741, 44 L.Ed.2d 208 (1975) (state shelter allowance provisions inconsistent with SSA); *Townsend v. Suank,* 404 U.S. 282, 92 S.Ct. 502, 30 L.Ed.2d 448 (1971) (state prohibition against AFDC aid for college students inconsistent with SSA); *King v. Smith,* 392 U.S. 309, 311, 88 S.Ct. 2128, 2130, 20 L.Ed. 2d 1118 (1968) (State cohabitation prohibition inconsistent with SSA). Cf. *Hagan v. Lavine,* 415 U.S. 528, 532-533, 543. 94 S.Ct. 1372, 1376-1377, 1382, 39 L.Ed.2d 577 (1974) (District Court held jurisdiction to decide whether state recoupment provisions consistent with SSA); *Carter v. Stanton,* 405 U.S. 669, 670, 92 S.Ct. 1232, 1233, 31 L.Ed.2d 569 (1972) (District Court had jurisdiction to decide whether state absent-spouse rule consistent with SSA).

Id., 448 U.S. at 6. *See also, Edelman v. Jordan,* 415 U.S. 651, 675 (1974).

Various federal circuit and district courts have therefore had little difficulty in exercising jurisdiction over claims founded upon Medicaid violations. *See, e.g., Nebraska Health Care Association v. Dunning,* 778 F.2d 1291, 1295-96 (8th Cir. 1985) *cert. denied,* — U.S. —, 107 S.Ct.

947 (1987) (state statute regulating reimbursement to providers of nursing home services found in violation of federal regulations and the "Boren Amendment," 42 U.S.C. § 1396a(a)(13)(A), complaint properly characterized as an action under 42 U.S.C. § 1983); *Yapalater v. Bates,* 494 F.Supp. 1349, 1358 (S.D.N.Y. 1980), *aff'd,* 644 F.2d 131 (2d Cir. 1981), *cert. denied,* 455 U.S. 908, 102 S.Ct. 1255, 71 L.Ed.2d 447 (1982) (a provider, who claims that State's "wrongful administration of the Medicaid program . . . deprives him of reimbursement to which federal law entitles him" has a remedy by virtue of "§ 1983 as interpreted by the *Thiboutot* majority"); *Washington State Health Facilities Association v. State of Washington Department of Social and Health Services,* 698 F.2d 964 (9th Cir. 1982) (state enforcement of a regulation which deviated from the federally approved state Medicaid plan enjoined); *Illinois Hospital Association v. Illinois Department of Public Aid,* 586 F.Supp. 360 (N.D. Ill. 1983); *Thomas v. Johnston,* 557 F.Supp. 879 (W.D. Tex. 1983) (§ 1983 action to enforce reimbursement provisions of 42 U.S.C. § 1396a(a)(13)(A) and federal regulations).

While this Court narrowed the scope of § 1983 availability somewhat in the *Pennhurst* decision, *Pennhurst State School and Hospital v. Halderman,* 654 U.S. 89, 104 S.Ct. 900, 79 L.Ed.2d 67 (1984), that decision in no way negated *Maine v. Thiboutot* nor altered its continued application to Social Security Act violations.

Petitioners have stated no cogent reason for reconsidering and overruling the narrow, but well settled principle of *Maine v. Thiboutot* as applied to the patients and provider of health care now before this Court.

Because the District Court had engaged in a *Pennhurst* analysis to arrive at its erroneous conclusions, (and probably out of an abundance of caution), the Ninth Circuit did examine the case under *Pennhurst* principles, even though it was not necessary to its holding. That is, it held that "*Thiboutot* rather than *Pennhurst* governs this case and it was not necessary [for the District Court] to engage in a *Pennhurst* analysis." Petitioners' App-2. After reviewing the case under *Pennhurst,* the Court was compelled to find that "[e]ven if *Penhurst* properly applies here, these plaintiffs can enforce 42 U.S.C. § 1396a (a)(13)(A)." *Id.*

In connection with its *Pennhurst* review, and particularly with respect to the "second *Pennhurst* exception", which "examines the character of the 'right' created by a federal statute," the Ninth Circuit found it appropriate to "borrow" from the *Cort v. Ash,* 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975), "implied right of action" theory. Under this analysis, the Court stated that "if a plaintiff is one of a class for whose especial benefit a statute was enacted, and if Congress has not expressly proscribed private actions to enforce the benefit, the entitlement will support a plaintiff's § 1983 action." Petitioners' App-4. Although stated somewhat differently, this was essentially the Court's approach in the recently decided case of *Wright v. Roanoke Redevelopment and Housing Authority,* — U.S. —, 107 S.Ct. 766, 770-71 (1987). Again, it should be noted that the analysis in *Wright* presupposes the necessity of a *Pennhurst* examination, a point which Respondents do not concede as appropriate here. However, even if examined under a *Pennhurst* approach as explained by *Wright,* it becomes clear that the Ninth Circuit's decision was correct.

As the Court stated in *Wright v. Roanoke Development and Housing Authority, supra,* 107 S.Ct. at 771,

> If there is a state deprivation of a 'right' secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement.

The Petitioners in this case, therefore, have the burden of demonstrating the requisite "congressional intent to preclude the remedy of suits under § 1983," and that "Congress specifically foreclosed [such a] remedy . . . ." *Id.,* quoting *Middlesex County Sewerage Authority v. National Sea Clammers Ass'n.,* 453 U.S. 1, 20, 101 S.Ct. 2615, 2626, 69 L.Ed.2d 435 (1981); *Smith v. Robinson,* 468 U.S. 992, 1004-1005, n. 9, 104 S.Ct. 3457, 3465-3466 n. 9, 82 L.Ed.2d 746 (1984). This they have not done and cannot do. They neglect to point out that if Congress wished to deny access to the federal system it could have included such a denial in Title XIX. But this Congress did not do. It has been approximately seven years since *Maine v. Thiboutot* was decided. If Congress was offended by this Court's interpretation of their intent, then Congress could have made that disagreement known in the six succeeding sessions since *Thiboutot.* As this Court has recognized, the silence of Congress can give rise to an indication of the Congresional intent. *See, Graves v. People of State of New York,* 306 U.S. 467, 479 (1939).

In determining whether Congress has foreclosed a private remedy. the Court must, of course, first look "at the language of the statute." *Daily Income Fund, Inc. v. Fox,* 464 U.S. 523, 534, 104 S.Ct. 831, 78 L.Ed.2d 645 (1984).

The statute in question here, 42 U.S.C. § 1396a(a)(13)(A), states in pertinent part, that a state plan for participants in the federal medicaid plan must, among other things:

> (13) provide—
>
> (A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility, services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in accordance with applicable State and Federal laws, regulations, and quality and safety standards, and to insure that individuals eligible for Medicaid assistance have reasonable access . . . .

Certainly nothing in the statute itself forecloses a private right of action.[2] Indeed, with its requirement of payment rates to providers of health care which will "meet [their] costs," when they are "efficiently and economically operated," Congress unmistakenly appears to place the provider within "the class for whose *especial* benefit the stat-

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[2]HCFA, the entity of HHS responsible for Medicaid reimbursement matters, apparently agrees that the federal courts are to be utilized in Medicaid reimbursement matters:

> Since the Medicaid program is State administered, it is neither appropriate nor administratively feasible to establish a Federal appeals process outside the current State administrative procedures or the State *and Federal* civil court systems. Finally, absent any statutory mandate, there is no Federal authority to require judicial recourse for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available in their States after they have exhausted the administrative appeal process. (Emphasis added)

See 48 Fed. Reg. 56047 (December 19, 1983).

ute was enacted." *Cort v. Ash, supra,* 422 U.S. at 78, *quoting Texas & Pacific R. Co. v. Rigsby,* 241 U.S. 33, 39 (1916). The Ninth Circuit correctly reasoned that *both* Medicaid patients *and* providers, both plaintiffs in this action, "have parallel interests with respect to Medicaid funding and reimbursement." Petitioners' App-5. *See, Blum v. Stenson,* 465 U.S. 886, 104 S.Ct. 1541, 79 L.Ed. 2d 891 (1984) (upheld award of attorneys' fees pursuant to § 1988 in a case brought under § 1983 on behalf of Medicaid recipients.)

In *Yapalater v. Bates,* 494 F.Supp. 1349 (S.D.N.Y. 1980) *aff'd.* 644 F.2d 131 (2d Cir. 1981) *cert. denied,* 455 U.S. 908, 102 S.Ct. 1255, 71 L.Ed. 2d 447 (1982), the District Court rejected the defendants' contention "that under the *Cort* analysis, plaintiff as a welfare *provider* has no federal right of action for an alleged violation of the Social Security Act under color of state law." (Emphasis original). *Id.* at 1355. Finding that the plaintiff is furnished a remedy under § 1983, and that the defendants' *Cort v. Ash* argument "goes to the merits" rather than to jurisdiction, the Court held:

> . . . within the § 1983 context, it distorts reality to characterize plaintiff as nothing but a "provider." To be sure, it was as a "provider" that plaintiff furnished Medicaid service; but the case at bar turns upon the legal measurement of his reimbursement. Thus he may be just as accurately described as a "recipient of reimbursement."

It is certainly the *provider,* not the patient, that must "incur costs" in providing care in conformance with federal and state laws and regulations. It is the *provider* which must conduct his operations in an "efficient and

economic'' manner so as to be eligible for reimbursement. It is the *provider* that has the economic stake in making certain that state Medicaid plans, at least their reimbursement aspects, are conducted in accordance with the federal statute and regulations.

Because *Maine v. Thiboutot* is applicable to the narrow situation in which Social Security Act violations are at issue, and also because the outcome of this case would be the same even if tested by the alternate *Pennhurst* approach with its reference to *Cort v. Ash,* and in light of the recent *Wright* decision, it would certainly be an ill-advised use of the Court's scarce time and resources to re-examine this matter.

B. No True Conflict Exists Between the Circuit Courts of Appeals With Respect To the Precise Issues Presented Here

Petitioners cite *Oberlander v. Perales,* 740 F.2d 116 (2d Cir. 1984) in support of their contention that ''lower federal courts have reached different conclusions on the availability of § 1983 relief for alleged medicaid rate violations.'' Petition at 16. However, that case turned on the Court's determination that the plaintiffs' allegations were limited to the ''state authority's failure to comply with *state regulations.*'' *Oberlander v. Perales, supra,* 740 F.2d at 119. Despite Petitioners' attempt to characterize the complaint in this case as pertaining only to state regulatory violations, *see, e.g.,* Petition at 6, as mentioned previously, a reading of the complaint itself leads to a contrary conclusion. Petitioners' App.-31-38. Clearly, a violation of the federal statutes and regulations is alleged and, at this point at least, must be accepted as true. *Hughes*

v. Rowe, supra. The Medicaid portion of Title XIX, perhaps more than many of the other portions of that Title already specifically recognized by this Court as within the federal court's jurisdiction, can be characterized as pervasively regulated by the federal government. *See, e.g.,* 42 C.F.R. § 431.1 *et seq.* While it is certainly true that the Medicaid program is a cooperative federal-state effort, the majority of the funding comes from the federal government. "Although participation in the Medicaid program [by a state] is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX." *Harris v. McRae,* 448 U.S. 297, 301 (1980).

The Title XIX requirement at issue in this case concerns the federal statutory and regulatory requirement that providers of health care under the various Medicaid programs be reimbursed at rates which are:

> reasonable and adequate to meet the costs which must be incured by efficiently and economically operated facilities in order to provide care in conformity with applicable state and federal laws, regulations and quality and safety standards.

42 U.C.S. § 1396a(a)(13)(A). *See also,* 42 C.F.F. § 447.250-447.253. The crux of the Complaint in this case was that the payment rates established by Oregon pursuant to its participation in the Medicaid program were not reasonable or adequate to meet the costs which were required to be incurred by the provider to provide care in conformity with federal and state standards for certain patients who require specialized or extra care, or as the state has termed it, "heavy care." The fact that the state has regulations

which also purport to require payment for these "heavy care" patients, and of which it may also be in violation, no way transforms the federal statutory obligation into a matter of purely state law.

As one Court has observed:

> The Social Security Act and its history evidences no legislative intent that disputes over changes of reimbursement methods between Medicaid providers and states be governed solely by state law.

Washington State Health Facilities Association v. State of Washington Department of Social and Health Services, 698 F.2d 964, 965 n. 4 (9th Cir. 1982).

The Eleventh Circuit in *Silver v. Baggiano,* 804 F.2d 1211, 1214 (1986) illustrated this point nicely in construing *Barnes v. Cohen,* 749 F.2d 1009 (3rd Cir. 1984), *cert. denied,* 471 U.S. 1061 (1985):

> In *Barnes,* the Third Circuit found that state officials were not adhering to their own regulations regarding their Aid to Families with Dependent Children ("AFDC") program. As a result, the court found that the state officials were violating the state AFDC plan. Moreover, since the federal AFDC statute requires that state AFDC plans "be in effect in all political subdivisions of the State, and if administered by them, be mandatory upon them," 42 U.S.C. § 602(a)(1), the Third Circuit held that state officials, by not adhering to their own regulations, had violated the state plan and thus had violated the federal law which makes the state plan mandatory. Therefore, because state officials were alleged to have violated federal law by not complying with state law, the Third Circuit decided that *Pennhurst II* was inapplicable.

While it may be true that an Oregon Medicaid regulation is involved in this action, the purpose of the regulation is to implement *federal* law which governs the state plan for Medicaid. And it is precisely the action/inaction under color of state law which uniquely violates those *federal* laws set forth clearly in plaintiffs' complaint and which clearly allows a § 1983 proceeding.

The fact that Congress repealed the statutes formerly requiring an Eleventh Amendment immunity waiver by States participating in the Medicaid program, 42 U.S.C. § 1396(g) (repealed), in no way alters the jurisdiction of the federal courts. It simply means that retroactive, monetary relief against a state may not be obtained in federal court. "The repealer does not affect the [provider's] right to prospective injunctive relief." *Hospital Association of New York State v. Toia,* 435 F.Supp. 819, 825 (S.D.N.Y. 1977) *referring to* Sen. Rep. No. 94-1240, U.S. Code Cong. and Admin. News, p. 5648 *et. seq.* (1976). Thus, reliance by Petitioners upon the repealer statute and the *Toia* decision in support of its contention that there is a Congressional preference for "state level" litigation of reimbursement claims is unfounded. In *Toia* itself, the federal judgment was vacated only "insofar as it award[ed] plaintiffs monetary relief against the State." *Id.* at 832. In this case, then, the federal court may clearly proceed upon plaintiffs' claims for declaratory and injunctive relief.

The *Oberlander* Court, in fact, correctly stated the applicable rule. "Suits in federal court under § 1983 are proper to secure compliance with provisions of the Social Security Act on the part of participating states." *Ober-*

lander v. Perales, 740 F.2d 116, 119 (2d Cir. 1984) *quoting Maine v. Thiboutot, supra,* 448 U.S. at 4. Again, the Second Circuit's specific holding was based upon its finding that a state regulation *alone* was at issue. The Ninth Circuit had little difficulty in this case recognizing that "*both* state laws and Title XIX of the Social Security Act" are at issue. Petitioners' App-1. In reality, then, there is no conflict between the Ninth and Second Circuits.

The *absence* of conflict is further seen by the Second Circuit's more recent decision in *Rose v. Heintz,* 806 F.2d 389 (1986). The case involved an award of attorney's fees pursuant to 42 U.S.C. § 1988 based upon the successful prosecution of a § 1983 claim against a state official and a Connecticut state agency. The case arose under Title XIX of the Social Security Act, specifically 42 U.S.C. § 1396a(a)(10)(A), and resulted in a judgment against the state defendants based on their Medicaid policy actions, which the Second Circuit noted were under color of *both* state and federal law. *Id.,* at 392. Contrary to Petitioners' assertions, then, (Petition 22) the Second Circuit does *not* conclude that claims seeking to enforce a state's compliance with its Medicaid plan raise no questions of federal law. Petitioners see a conflict where none exists.

Petitioner also cites some district court decisions in support of its contention that a conflict of authority exists among the circuits. However, Rule 17, Rules of the Supreme Court refers only to "conflict[s] with the decision of *another federal court of appeals,*" and thus a conflict among district courts, even if such a conflict exists, is not within the coverage of the rule at all. Indeed, it has been suggested that:

> [T]he existence of differing rules of law in different sections of our great country is not always an intolerable evil . . . experience with conflicting interpretations . . . may help to illuminate an issue before it is finally resolved and thus may play a constructive role in the lawmaking process. The doctrine of judicial restraint teaches us that patience in the judicial resolution of conflicts may sometimes produce desireable results.

Stevens, J. *Some Thoughts on Judicial Restraint,* 66 Judicature 177, 183 (1982). Therefore, even if it could possibly be agreed, arguendo, that a conflict exists between the Second and Ninth Circuits, the "conflict" appears to be a "tolerable" one.

II. PETITIONERS' "EXHAUSTION" CONTENTION DOES NOT MERIT THE COURT'S REVIEW

This Court has made it clear that administrative remedies need not be exhausted as a prerequisite to bringing an action under § 1983. *Patsy v. Board of Regents,* 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982); *Thomas v. Texas State Board of Medical Examiners,* 897 F.2d 453 (5th Cir. 1987). In particular, exhaustion will not be required where resort to administrative remedies would be "futile". *See, e.g., Smith v. Illinois Bell Tel. Co.,* 270 U.S. 587, 46 S.Ct. 408, 70 L.Ed. 2d 747 (1926); *United States Alkali Export Association v. United States,* 325 U.S. 196, 65 S.Ct. 1120, 89 L.Ed.2d 1554 (1945). The uncontroverted record in this case demonstrates that the "futility" rule applies here.

During the proceedings in the District Court, plaintiffs submitted the affidavit of Robert Decker, one of the principals in Coos Bay Care Center, Inc. The affidavit

also became part of the record presented to the Ninth Circuit Court of Appeals, and is set forth herein as Respondent's Appendix-1 *et seq.* The affidavit, in pertinent part states:

> Your affiant has been advised repeatedly that although these patients do require heavy care, that there is no money available to meet these patients' needs which would be indicated by federal law. *Your affiant has been told by these Oregon state officials that it would be futile to pursue any type of administrative procedure or administrative remedy and that, in fact, no administrative procedures were available to your affiant or to his patients which could address this type of problem.* Your affiant has further been told that no request for additional funding will be made by the State of Oregon for heavy care patients and, accordingly, your affiant has come to this court for relief under the federal jurisdiction and pursuant to federal law.

(Emphasis added). Nowhere in any of the proceedings below did Petitioners, by way of affidavit, argument or otherwise, even attempt to refute Mr. Decker's assertions. A Court may always exercise its discretion in determining whether exhaustion is required in a given case. *McKart v. United States,* 395 U.S. 185, 200-01, 89 S.Ct. 1657, 23 L.Ed.2d 194 (1969); *Natural Gas Pipeline Co. v. Slattery,* 302 U.S. 300, 58 S.Ct. 199, 82 L.Ed.2d 276 (1937). Given the facts and circumstances of this case, including the unrefuted assertions referred to above, plaintiffs can hardly be faulted for resorting to the courts. Indeed, in the face of the position of the state, resorting to state remedies would seem to be the very height of futility. *Lopez v. Heckler,* 725 F.2d 1489, 1501 (9th Cir. 1984) *Citing Wein-*

berger v. Salfi, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975).

CONCLUSION

Chief Justice Marshall observed that a federal court has "no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given" in *Cohens v. Virginia,* 6 Wheat 264 (1821). Now, as then, federal courts must take up federal questions.

Petitioners and their *amici* argue that floodgates will open and the federal courts will be swamped if plaintiffs are allowed to go forward. Though the federal decisions cited above favor plaintiffs' position, it should be noted that these cases are not that abundant, much less overwhelming. This Court correctly observed in a Medicare context, *Bowen v. Michigan Academy of Family Physicians,* — U.S. —, 106 S.Ct. 2133 (1986):

> We do not believe our decision will open the floodgates to millions of Part B Medicare claims. Unlike the *determinations* of amounts of benefits, the *method* by which such amounts are determined ordinarily affects vast sums of money and thus differs qualitatively from the "quite minor matters" review of which Congress confined to hearings by carriers. In addition, as one commentator pointed out, "permitting review only [of] . . . a particular statutory or administrative standard . . . would not result in a costly flood of litigation, because the validity of a standard can be readily established, at times even in a single case." Note, 97 Harv.L.Rev. 778, 792 (1984) (footnote omitted). We observed no flood of litigation in the first 20 years of

> operation of Part B of the Medicare program, and we seriously doubt that we will be inundated in the future.

Id., at 2131, fn.11. Like *Bowen, supra,* this case does not involve a single reimbursement decision, but a policy and continued *method* of denying the operation of federal laws under color of state law. Hopefully, the *amici* states' Medicaid systems are consonant with federal law. If so, there should be no wholesale stampede to the federal courthouse nearest their state capitals, and their concern with federal oversight is probably unwarranted.

From the point of view of the federal majority partner in Medicaid matters, is it not better to avoid 50 different interpretations of what federal law requires? That is to say, there is an absolute *necessity* for federal jurisdiction here to promote consistency in the responsible discharge of federally imposed duties. There is a logical consistency here. The Social Security Act must be implemented and judged by federal decisionmakers. That was recognized in *Maine v. Thiboutot* and has caused no unnecessary strains on the federal judiciary to date.

The Court should refuse to grant Petitioners' request for Certiorari because: (1) the issues presented in Petitioner's Petition were considered and correctly decided by the Ninth Circuit, (2) no actual conflict exists between the Circuits with respect to the precise issues presented herein, and (3) the doctrine of exhaustion of administrative remedies has no application here.

Respectfully submitted,

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APPENDIX A

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OREGON

Civil No. 84-6178-C

COOS BAY CARE CENTER, an Oregon corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,

Plaintiffs,

vs.

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,

Defendants.

AFFIDAVIT OF ROBERT DECKER IN OPPOSITION TO MOTION TO DISMISS

STATE OF OREGON)
) ss.
County of Marion)

COMES NOW, ROBERT DECKER, and being first duly sworn upon his oath, deposes and says:

That he is one of the owners of the Coos Bay Care Center, Inc., plaintiff herein.

That your affiant has been involved in rendering services to the developmentally disabled since at least 1962.

That he is the former director of the Idaho State School and Hospital for the developmentally disabled in the State of Idaho and that he is the former assistant director of the State of Utah, State Training School for the developmentally disabled during the years 1962 to 1969.

That your affiant is extensively involved with intermediate care facilities for the developmentally disabled in his capacity as Executive Vice President of Chartham Management, Inc., headquartered in Salem, Oregon. The principal business of Chartham Management, Inc., is to provide management services to health care facilities in the Western United States.

Your affiant knows of his own knowledge that the Coos Bay Care Center has been managed by Chartham Management, Inc., and owned by the present ownership since April of 1982. At that time, there were heavy care patients who were being reimbursed at the same rate as intermediate care patients at the Coos Bay Care Center.

Heavy care patients, as defined in Section 411-70-030, *Oregon Guide for Title XIX, Medicaid Assistance Programs,* by virtue of their disabilities, require a significant

amount of health care, attention, feeding, grooming and other services which exceed that demanded by the normal intermediate care patient.

That since April of 1982 and with respect to the heavy care patients who were in the facility in April of 1982 and those who have been admitted since, your affiant has discussed the need for additional reimbursement for the care given and for the care required by these patients. These needs have been discussed many times with the defendant, Richard C. Ladd, with Mr. Joe Morgan, assistant director of mental health for the State of Oregon, Mr. Bob Zigan, assistant director of senior services division, State of Oregon and various members of their staff.

Your affiant has been advised repeatedly that although these patients do require heavy care, that there is no money available to meet these patients needs which would be indicated by federal law. Your affiant has been told by these Oregon State officials that it would be futile to pursue any type of administrative procedure or administrative remedy and that, in fact, no administrative procedures were available to your affiant or to his patients which could address this type of problem. Your affiant has further been told that no request for additional funding will be made by the State of Oregon for heavy care patients and, accordingly, your affiant has come to this Court for relief under the federal jurisdiction and pursuant to federal law.

Your affiant is unaware of any Oregon definition of "economy" or "efficiency" as those terms relate to costs necessarily incurred by a Medicaid provider of services who must comply with federal and state requirements.

However, your affiant can state with certainty that however economy and efficiency are measured, the Coos Bay Care Center is not being reimbursed for its care of Medicaid patients at a rate sufficient to meet the costs which must be incurred by this efficiently and economically operated provider in order to provide services pursuant to Title XIX and in conformity with applicable State and Federal laws, regulations and quality and safety standards. That is to say, the Coos Bay Care Center, in your affiant's opinion is very efficiently and economically operated, yet it is not being reimbursed by the State of Oregon at a rate sufficient to met its costs.

Further your affiant sayeth not.

DATED THIS — day of ————————, 1984.

ROBERT DECKER

SUBSCRIBED AND SWORN to before me this — day of ————————, 1984.

NOTARY PUBLIC FOR OREGON

Residing at: .....

My Commission Expires: .....

CERTIFICATE OF MAILING

I HEREBY CERTIFY that on this 25 day of July, 1984, a true and correct copy of the within and foregoing AFFIDAVIT OF ROBERT DECKER was mailed, via Federal Express, to Thomas K. Elden, OSB# 79036, Assistant Attorney General, 450 Justice Building, Salem, Oregon 97310.

/s/ Larry L. Grant for
Donald W. Lojek

Supreme Court, U.S.
FILED
JUL 25 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1419

In the Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MARCH 2, 1987
CERTIORARI GRANTED MAY 4, 1987

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Respondents' Complaint 2

Intermediate Care Facility Agreement 10

Addendum to Agreement for Participation in the Title XIX Heavy Cost Program 15

Affidavit of Robert Decker in Opposition to Motion to Dismiss 17

The following opinion, order and findings and recommendations have been omitted in printing this appendix, because they appear on the following pages of the printed petition for certiorari:

Opinion of the Ninth Circuit Court of Appeals, dated November 3, 1986 ..... App-1

Order of the United States District Court, dated July 10, 1985 ..... App-7

Findings and Recommendations of Federal Magistrate, dated April 8, 1985 ..... App-9

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

Apr. 27, 1984—Plaintiffs' Complaint for Breach of Contract; Violation of Federal Constitution and Statutes; Class Action and Demand for Jury Trial filed in the United States District Court for the District of Oregon.

June 24, 1984—Defendants' Fed. R. Civ. P. 12 Motions filed in the United States District Court for the District of Oregon.

July 31, 1984—Plaintiffs' Affidavit of Robert Decker in Opposition to Motion to Dismiss.

Apr. 8, 1985—Federal Magistrate's Findings and Recommendations issued recommending dismissal of plaintiff's claims.

July 10, 1985—Order and Judgment of the United States District Court for the District of Oregon.

July 24, 1985—Plaintiffs filed Notice of Appeal in the United States Court of Appeals for the Ninth Circuit.

Nov. 3, 1986—Opinion of the United States Court of Appeals for the Ninth Circuit.

Mar. 2, 1987—Defendants' Petition for Writ of Certiorari filed.

May 4, 1987—Certiorari granted.

RESPONDENTS' COMPLAINT

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OREGON

[List of attorneys omitted in printing]

COOS BAY CARE CENTER, an Oregon corporation, (Guardian Ad Litems); HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer, on their own behalf and on behalf of a similarly situated class of individuals,	Case No. _____
Plaintiffs,	COMPLAINT FOR BREACH OF CONTRACT; VIOLATION OF FEDERAL CONSTITUTION AND STATUTES; CLASS ACTION AND DEMAND FOR JURY TRIAL
vs.	
STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD in his official capacity as Administrator of the Senior Services Division of the Department of Human Resources,	
Defendants.	

COME NOW, Plaintiffs, by and through their attorneys of record, PARKINSON, LOJEK & PENLAND, CHARTERED, and HARLAND, RITTER, SAALFELD & GRIGGS, and for their cause of action against the Defendants, complain and allege as follows:

1. Plaintiff, Coos Bay Care Center, Inc., is an Oregon corporation with its principal place of business in Coos Bay, County of Coos, Oregon.

2. The named Plaintiffs are Hanna Schwanke and Sandy Mauer, Guardians Ad Litem, respectively, for David and Steven Schwanke and Tami Mauer, who are heavy care patients at the Coos Bay Care Center, Coos Bay, Oregon. All named Plaintiffs are Oregon residents.

3. Title XIX of the Social Security Act, as amended, commonly known as "Medicaid," provides for medical assistance to the indigent and developmentally disabled in the form of a cooperative program between each of the participating states and the United States of America.

4. Defendant, Department of Human Resources, pursuant to Oregon Revised Statutes 184.750 and 441.060, is an agency of the State of Oregon and is responsible for administering the Title XIX medical assistance program within the State of Oregon.

5. Defendant, Richard C. Ladd, is the person responsible for the administration of the State of Oregon, Department of Human Resources, and, at all material times hereto, has acted under color of state law.

6. The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1331. The Plaintiffs' claims arising under Oregon law as more particularly stated herein are within the pendent jurisdiction of the Court since they arise out of a common nucleus of facts with the federal claims presented herein and are of such a nature that the Plaintiffs would ordinarily be expected to try all such claims in one proceeding.

7. Coos Bay Care Center, Inc. is engaged in the principal business of providing long-term care to the developmentally disabled and to the aged.

8. Coos Bay Care Center, Inc. is a licensed Intermediate Care Facility under the laws of the State of Oregon and has been so licensed at all material times hereto.

9. Coos Bay Care Center, Inc. on the 5th day of May, 1982, entered into an agreement with the Defendant State of Oregon, Department of Human Resources, Senior Services Division, for providing care under the Oregon Title XIX medical assistance program as an Intermediate Care Facility. A copy of the aforesaid agreement between Plaintiff, Coos Bay Care Center, Inc., and the Defendants is attached to this Complaint as Exhibit "A".

10. Plaintiffs David and Steven Schwanke and Tami Mauer are third party beneficiaries of this agreement and may maintain an action upon it.

11. The aforesaid agreement, *inter alia*, compels Coos Bay Care Center, Inc., (provider) and the Defendants to comply with applicable federal regulations as more particularly set forth at 42 C.F.R. § 442.300 and 42 C.F.R. § 442.250 and other regulations, as adopted.

12. The aforesaid agreement further obligates the Defendants to make payments to the provider in accordance with all federal and Oregon Administrative Rules applicable to Intermediate Care Facilities under the Title XIX Long-Term Care Facility Services Program existing within the State of Oregon.

13. The Title XIX program is established by the Social Security Act, as amended, 42 U.S.C. § 1396a *et seq.* and Oregon has chosen to participate therein. This program makes the State of Oregon responsible for the administration of state funds and the federal contribution under Title XIX of the Social Security Act, as amended.

14. Oregon has established a Medical Assistance Program (Medicaid) within the State which compels compliance with the State's own statutory terms and conditions thereof as well as all applicable regulations promulgated by the Department of Health and Human Services of the United States of America.

15. 42 U.S.C. § 1396a(a)(13)(A), particularly, provides that the state plan adopted by each state must contain

assurances satisfactory to the Secretary of the Department of Health & Human Services that established rates of reimbursement to participating medicaid providers are determined in accordance with methods and standards developed by the state and are reasonable and adequate to meet the costs which must be incurred by those providers who are efficiently and economically operated as they provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

16. Further, 42 C.F.R. § 447.252(a) provides that the single state agency responsible for administering the medicaid program within that state must pay for long term care rendered under the medical assistance program at a level which is sufficient to meet the costs which must be incurred by an efficiently and economically operated long term health care facility.

17. Additionally, § 411-70-030, of the Department of Human Resources, Senior Services Division, Nursing Facility Services Guide for Title XIX Medical Assistance Programs, provides, *inter alia*, for specific and complete reimbursement for provision of heavy cost care.

18. "Heavy care" patients are those who, by virtue of their medical or developmental problems, require significantly more or greater care than does the ordinary intermediate patient.

19. The heavy cost rates must include and reimburse for all nursing staff services, food or food substitutes, dressings, catheters and other special supplies as detailed in Rules 411-70-085 and 411-70-090.

20. The heavy cost rate does not include certain medical services as stated in Regulation 411-70-030(7)(a). Heavy cost care patients may be eligible under this rule and covered by rates for reimbursement in accordance with the rule.

21. There are now and have for some time been a number of patients at the Coos Bay Care Center, and at other similar

institutions within the State of Oregon, who are eligible for heavy cost care.

22. Patients at Coos Bay Care Center have been duly certified by physicians who have executed a Heavy Care Assessment and who have certified that the needs of the patient conform to the aforesaid rules and regulations of the Senior Services Division of the Department of Human Resources, State of Oregon.

23. In spite of the qualification of the patients, the State of Oregon and Defendant Richard C. Ladd, acting under color of state law, have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients to and on behalf of the Plaintiffs, thus denying them due process of law guaranteed by the Fifth and Fourteenth Amendments to the Constitution of the United States of America and resulting in a taking of property for public use without just compensation. Accordingly, the Plaintiffs' wards, David and Steven Schwanke and Tami Mauer, and the class they represent do not receive the quantity or quality of care guaranteed to them constitutionally and by state and federal laws, statutes and regulations as aforesaid, although Plaintiff Coos Bay Care Center does afford "heavy care" patients as much "heavy care" as possible.

24. Throughout the State of Oregon there are other heavy care patients residing within long-term health care facilities who similarly qualify for heavy care but who do not receive the full amount of appropriate care because of the refusal of the Defendants to appropriately reimburse health care providers for such care.

CLASS ACTION ALLEGATIONS

25. Plaintiffs therefore bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedure on their own behalf and on behalf of all other residents of licensed long term health care facilities within the State of Oregon who, as a

result of Defendants' actions, or non-action, have not been granted full medical assistance commensurate with their status as heavy care patients as more particularly described below.

26. The number of heavy care patients in the Plaintiff class is so numerous that the joinder of all members of the class is impracticable. Upon information and belief, the named Plaintiffs aver that the number of heavy care patients in the proposed class exceeds 100 patients, statewide.

27. The claims of the representative Plaintiffs are typical of the Plaintiff class and arise out of identical facts constituting the unlawful conduct of the Defendants. The representative Plaintiffs will fairly and adequately protect the interests of the Plaintiff class.

28. This action may be maintained as a class action pursuant to Rule 23(a)(2) of the Federal Rules of Civil Procedure since Defendants have acted and refuse to act on grounds generally applicable to the Plaintiff class, thereby making appropriate final declaratory relief with respect to the class as a whole.

29. This action may be maintained as a class action pursuant to Rule 23(b)(3) of the Federal Rules of Civil Procedure since the questions of law and fact common to the claims of the Plaintiff class and resulting from Defendants' actions predominate over any questions affecting only individual members. The successful assertion of the claims of the named Plaintiffs necessarily establish determinations of fact and law adequate to prove the unlawful actions of Defendants, thereby making a class action superior to any other available method for the fair and efficient adjudication of the claims of the named Plaintiff class.

FIRST CAUSE OF ACTION

30. Plaintiffs hereby incorporate and reallege paragraphs 1 through 29 in this paragraph as if fully set forth herein.

31. The aforesaid course of conduct by the Defendants violates 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252.

32. As a direct and proximate result of the violation of these statutes and regulations the Plaintiffs have been damaged in the approximate amount of $138,600.00 and will continue to be irreparably damaged in the amount of the differential between the heavy cost care afforded and routine care.

SECOND CAUSE OF ACTION

33. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

34. The aforesaid course of conduct by the Defendants constitutes a breach of contract by the Defendants.

35. As a proximate result of this breach of contract the Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and will continue to be damaged on a daily basis. Plaintiffs Schwanke and Mauer and the class they represent will continue not to be afforded the full measure of heavy cost care to which they are entitled.

THIRD CAUSE OF ACTION

36. Plaintiffs hereby incorporate paragraphs 1 through 29 in this paragraph as if fully set forth herein.

37. The aforesaid course of conduct by the individual Defendants constitutes a violation of 42 U.S.C. § 1983 in depriving the Plaintiffs of their constitutional rights under the Fourteenth Amendment of the United States Constitution and their statutory rights, both state and federal, as aforesaid.

38. As a proximate result of the violation of Plaintiffs' constitutional rights, Plaintiff Coos Bay Care Center has been damaged in the amount of $138,600.00 and Plaintiffs Mauer, Schwanke and each member of the class they represent have been damaged in the amount of $10,000.00.

39. Plaintiffs hereby claim all necessary and proper attorney's fees in accordance with 42 U.S.C. § 1988.

WHEREFORE, Plaintiffs pray for relief as follows:

1. For a declaratory judgment of this Court that those medicaid patients in Oregon long term health care facilities who are certified as heavy care patients be recognized as such by the State of Oregon in accordance with the rules and regulations of the State of Oregon and the United States, Department of Health & Human Services, and that those long-term health care facilities who provide care to such patients be reimbursed appropriately.

2. For a further order from this Court to direct the Defendants to conform to the aforesaid Federal statutes and regulations in their reimbursement methodology in the administration of the Medicaid program.

3. For a further declaratory judgment that the agreement between Plaintiff Coos Bay Care Center and the State of Oregon has been breached by the State and that the Plaintiffs have been and are being damaged thereby.

4. For an injunction prohibiting the Defendants from violating federal and state law, as alleged.

5. For damages pursuant to 42 U.S.C. § 1983, in the amount of $138,600.00 to Plaintiff Coos Bay Care Center which represents the lack of appropriate reimbursement from May 26, 1982, to the date of judgment, and for an award of $10,000.00 each to the other named Plaintiffs and to each member of the class they represent.

6. For Plaintiffs' attorney's fees, costs and expenses reasonably incurred in bringing this cause of action pursuant to 42 U.S.C. § 1988 and the Federal Rules of Civil Procedure.

7. For such other and further relief as to this Court seems just.

Dated this 27th day of April, 1984.

[Signatures omitted in printing]

INTERMEDIATE CARE FACILITY AGREEMENT
[filed June 10, 1981]
[letterheads omitted in printing]

This Agreement is between the Department of Human Resources of the State of Oregon, through the Senior Services Division, hereinafter referred to as Division and

Coos Bay Care Center, Inc.
2625 Koos Bay Boulevard
Coos Bay, Oregon 97420

hereinafter referred to as Provider.

INTRODUCTION

Pursuant to ORS 184.750 and ORS 441.060, the Department of Human Resources, through AFS Division, is the agency responsible for administering the Title XIX Medical Assistance Program in Oregon. By Agreement the SSD Administers the Title XIX Long-Term Care Services Program.

Section 1902 (a)(27) of Title XIX of the Social Security Act requires a State to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance.

To participate in the Oregon Title XIX Medical Assistance Program, an Intermediate Care Facility must: (1) be licensed as a nursing home or hospital under the laws of Oregon; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing home administrator who holds a current license or by a hospital administrator; and (4) meet on a continuing basis federal standards for participation in the Title XIX Medical Assistance Program.

Provider has filed an application with the State Health Division to provide, as a [*sic*] Intermediate Care Facility, health-related care and services to any and all persons eligible for the Title XIX Medical Assistance Program. The application is attached hereto and made a part of this Agreement.

All conditions apply to recipients who are receiving assistance under the General Assistance Program.

I. PROVIDER AGREES TO:

A. Comply with all Oregon Administrative Rules And State Statutes applicable to Intermediate Care Facilities under the Title XIX Long-Term Care Facility Services Program;

B. Comply with all applicable regulations as stated in the Title XIX Social Security Act and amendments thereto;

C. Inform Division promptly when individuals covered under the Title XIX Program are admitted to and discharged from the Intermediate Care Facility;

D. Notify Division immediately of any change in operating license issued by the State Health Division;

E. Respect the observance of religious beliefs of all Title XIX patients;

F. Provide cooperative methods and procedures relating to the utilization of care and services available as may be necessary to safeguard against unnecessary utilization of such care and services;

G. Submit annual cost statements within the time limits, using the forms and instructions specified in the Title XIX Long-Term Care Facility Services Guide.

H. Submit billings for SSD clients showing correct resident day counts, resident income, and payment rates.

I. Make available to appropriate State and Federal personnel at all reasonable times all necessary records, retain medical records for a minimum of seven years, and financial records for a minimum of three years from the date all audit questions have been resolved. Records will include at least the following:

1. Records as required by Section 1905 (c) and (d) of Title XIX of the Social Security Act, and any amendments thereto;

2. Records of all treatments, drugs, and services for which provider payments are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drugs, or services; and

3. All other records as may be found necessary by the Division in compliance with any Federal or State

law, rule, or regulation promulgated by the United States Department of Health and Human Services, or by the Division.

J. Accept payment from the Division as payment in full for those services, goods and products included in the all-inclusive per diem rate, with the understanding that:

Whosoever knowingly and willfully: (1) charges for any such service, goods or products in excess of the all-inclusive per diem rate established by the Division; or (2) charges, solicits, accepts or receives, in addition to the amount paid by the Division, any gift, money, donation or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident) as a precondition of admitting a resident to an intermediate care facility, or as a requirement for the resident's continued stay in such a facility, shall be quilty [*sic*] of a (federal) felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years or both.

K. No individual will be employed in a management or supervisory capacity who has been convicted of a criminal offense involving Medicaid or Medicare laws, rules or regulations;

L. Meet conditions for participation as an Intermediate Care Facility required by Federal Regulations 42 CFR 442.300 meet the definition of an Intermediate Care Facility as set forth under 42 CFR 442.252; and meet 42 CFR 442.311 relating to patients rights and protection of patient funds.

II. DIVISION AGREES TO:

A. Make payments to the Provider in accordance with all Oregon Administrative Rules applicable to Intermediate Care Facilities under the Title XIX Long-Term Care Facility Services Program, as soon as feasible after a proper claim is submitted and approved.

B. Give Provider reasonable notice of any impending change in status under the Title XIX Medical Assistance Program.

III. PROVIDER AND DIVISION MUTUALLY AGREE THAT:

A. Both Provider and Division are discharged from further obligation created under terms of this Agreement, except for equitable settlement of respective accrued interests up to date of the termination, if federal and/or state laws are amended, repealed, or judicially interpreted so as to render fulfillment of this Agreement on the part of either party infeasible or impossible;

B. The term of this Agreement shall be in accordance with the certification by the State Health Division.

C. This Agreement may be terminated by mutual consent of the Division and the Intermediate Care Facility, or by written 30-day notice by either party;

D. If the Intermediate Care Facility certification is voluntarily or involuntarily terminated, the Division agrees to remove all Title XIX residents from the decertified beds provided that the facility has secured prior consent to removal from the residents and/or their responsible relatives. Removal is to be completed within 30 days of the termination of this Agreement. In the event of voluntary or involuntary termination of this Agreement, in those cases where consent has not been obtained, The Division will assist in removing clients upon request by The Provider or residents. In all cases, however, the Division will discontinue payment for Title XIX Intermediate Care Facility services no later than 30 days subsequent to the termination of this Agreement;

E. Provider and Division mutually agree that if the Health Division has notified the Division in writing that a facility is deficient in areas relating to patient care and the Health Division has made a termination of potential decertification (see Rule 461-17-090), this Agreement will be modified by the Division for the period determined by the Health Division that the facility is in a status of potential decertification. Modification of the Agreement will be limited to making no payment for residents admitted to the facility or who become eligible for assistance while in

the facility during the period of potential decertification;

F. Comply with Title VI, Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;

G. This agreement shall not be transferable or assignable;

H. This Agreement is contingent upon the Provider correcting deficiencies in accordance with the written Plan of Correction submitted by Provider to the State Health Division and approved by that agency;

I. Conviction of the owner, or anyone having an ownership interest in the facility, or a criminal act involving Medicaid or Medicare laws, rules or regulations will be grounds for termination of this Agreement by the Division;

J. Any breach or violation of any of the foregoing provision shall make this Agreement subject to immediate concellation;

K. Division may withhold payment as necessary because of violation of this Agreement until the violation can be remedied;

L. Provider, by entering into this Agreement, does not waive any right to contest the legality and validity of any statutes, regulations, and rules established by the Federal Government, State Health Division, Senior Services Division, any SSD branch office, State of Oregon, or any other governmental or private entity.

This Agreement remains in effect until: December 31, 1983.

This Agreement shall not become effective until approved by the Senior Services Division, State of Oregon.

[Signatures omitted in printing]

Addendum to Agreement
for
Participation in the Title XIX Heavy Cost Program

Notwithstanding the provisions of that Agreement, it is further agreed and understood between Oregon State Senior Services Division (SSD) and,

Coos Bay Care Center, Inc.
2625 Koos Bay Boulevard
Coos Bay, Oregon 97420

hereinafter designated as Facility, as follows:

Senior Services agrees to pay Facility a special daily rate established by Division for the care of individuals identified by Division as eligible for 'heavy cost' care. The client must occupy a bed certified by the State Health Division and covered by an agreement with the Division. The 'heavy cost' payment for an eligible individual is in effect for a period specified by Division and extension will be re-assessed as determined by Division. The Facility agrees to provide supplies and services included in the all-inclusive rate, as specified in the Title XIX Long-Term Care Facility Services Guide. In addition, the facility will provide all exceptional nursing or personal services as required based on an assessment by the Division. The 'heavy cost' rate does not include those medical services, i.e. physician, physical therapy, pharmacy, dental, etc., paid through Title XIX, Title XVIII, Veterans Administration, etc., and personal incidental items authorized for payment from the client's personal incidental allowance (see Rule 461-17-160).

The Facility will maintain detailed, complete and accurate records of the care provided and the costs of the care. Records of services and costs will be made available to the Division upon request.

The modification, cancellation or continuation of the arrangement set forth in this addendum will be the responsibility of Division to renegotiate with the Facility.

This addendum is in effect until December 31, 1983. contingent upon the nursing facility agreement remaining in effect for this period.

This addendum may be cancelled by either party giving 60 days notice to the other party of intention to do so.

[Signatures omitted in printing]

AFFIDAVIT OF ROBERT DECKER IN OPPOSITION TO MOTION TO DISMISS

[filed July 31, 1984]

[List of attorneys omitted in printing]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OREGON

[Title of case omitted in printing]

COMES NOW, ROBERT DECKER, and being first duly sworn upon his oath, deposes and says:

That he is one of the owners of the Coos Bay Care Center, Inc., plaintiff herein.

That your affiant has been involved in rendering services to the developmentally disabled since at least 1962.

That he is the former director of the Idaho State School and Hospital for the developmentally disabled in the State of Idaho and that he is the former assistant director of the State of Utah, State Training School for the developmentally disabled during the years 1962 to 1969.

That your affiant is extensively involved with intermediate care facilities for the developmentally disabled in his capacity as Executive Vice President of Chartham Management, Inc., headquartered in Salem, Oregon. The principal business of Chartham Management, Inc, is to provide management services to health care facilities in the Western United States.

Your affiant knows of his own knowledge that the Coos Bay Care Center has been managed by Chartham Management, Inc. and owned by the present ownership since April of 1982. At that time, there were heavy care patients who were being reimbursed at the same rate as intermediate care patients at the Coos Bay Care Center.

Heavy care patients, as defined in Section 411-70-030, *Oregon Guide for Title XIX, Medicaid Assistance Programs*, by virtue of their disabilities, require a significant amount of

health care, attention, feeding, grooming and other services which exceed that demanded by the normal intermediate care patient.

That since April of 1982 and with respect to the heavy care patients who were in the facility in April of 1982 and those who have been admitted since, your affiant has discussed the need for additional reimbursement for the care given and for the care required by these patients. These needs have been discussed many times with the defendant, Richard C. Ladd, with Mr. Joe Morgan, assistant director of mental health for the State of Oregon, Mr. Bob Zigan, assistant director of senior services division, State of Oregon and various members of their staff.

Your affiant has been advised repeatedly that although these patients do require heavy care, that there is no money available to meet these patients [*sic*] needs which would be indicated by federal law. Your affiant has been told by these Oregon State officials that it would be futile to pursue any type of administrative procedure or administrative remedy and that, in fact, no administrative procedures were available to your affiant or to his patients which could address this type of problem. Your affiant has further been told that no request for additional funding will be made by the State of Oregon for heavy care patients and, accordingly, your affiant has come to this Court for relief under the federal jurisdiction and pursuant to federal law.

Your affiant is unaware of any Oregon definition of "economy" or "efficiency" as those terms relate to costs necessarily incurred by a Medicaid provider of services who must comply with federal and state requirements. However, your affiant can state with certainty that however economy and efficiency are measured, the Coos Bay Care Center is not being reimbursed for its care of Medicaid patients at a rate sufficient to meet the costs which must be incurred by this

efficiently and economically operated provider in order to provide services pursuant to Title XIX and in conformity with applicable State and Federal laws, regulations and quality and safety standards. That is to say, the Coos Bay Care Center, in your affiant's opinion is very efficiently and economically operated, yet it is not being reimbursed by the State of Oregon at a rate sufficient to meet its costs.

Further your affiant sayeth not.

DATED This ___ day of _____, 1984.

[signatures and certification omitted in printing]

OPINION OF THE NINTH CIRCUIT COURT OF APPEALS

[Opinion set forth in full as Appendix A, pages App-1 to App-6 of the printed petition for certiorari]

ORDER OF THE UNITED STATES DISTRICT COURT

[Order set forth in full as Appendix B, pages App-7 to App-8 of the printed petition for certiorari]

FINDINGS AND RECOMMENDATION OF FEDERAL MAGISTRATE

[Findings and recommendation set forth in full as Appendix C, pages App-9 to App-15 of the printed petition for certiorari]

No. 86-1419

Supreme Court, U.S.
FILED
JUL 25 1987
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF FOR PETITIONERS

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QUESTION PRESENTED

Do the rate reimbursement provisions established by the states in their Medicaid plans give rise to federal rights enforceable in federal court under 42 U.S.C. § 1983, when the pertinent parts of the federal Medicaid Act and its implementing regulations provide that reimbursement standards and administrative review procedures shall be established by the states?

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the Ninth Circuit Court of Appeals is reported as *Coos Bay Care Center v. State of Oregon, Department of Human Resources*, 803 F.2d 1060 (9th Cir. 1986). (Pet. App. A). The order and judgment of the district court is unreported. (Pet. App. B). The magistrate's Findings and Recommendations also are unreported. (Pet. App. C). The magistrate relied substantially upon the earlier decision of the District Court of Oregon in *Beecroft v. Atiyeh*, Civil No. 78-1027-BU (1982) which also is unreported. (Pet. App. D).

JURISDICTION

The opinion of the Ninth Circuit Court of Appeals was dated and filed on November 3, 1986. Judgment was entered on the same date. This Court has jurisdiction to review the judgment in this civil case by writ of certiorari pursuant to 28 U.S.C. § 1254(1) (1982). By order dated January 20, 1987, the Court extended the time for filing a petition for writ of certiorari to March 3, 1987. The petition was filed within the time allowed and was granted by this Court on May 4, 1987.

STATUTES AND REGULATIONS INVOLVED

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982),[1] provides, in pertinent part:

> § 1396. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services,

[1] 42 U.S.C. §§ 1396 *et seq.* have been amended since the date plaintiffs filed their complaint. However, the amendments do not have any substantial effect upon this case.

and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, ~~there is~~ hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, . . . State plans for medical assistance.

§ 1396a(a) A State plan for medical assistance must—

. . . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

. . . .

(13) provide—

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; . . . .

. . . .

(37) provide for claims payment procedures which . . . (B) provide for procedures of prepayment and postpayment claims ~~review~~, including review of appropriate data with respect to the recipient and provider

of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

. . . .

2. 42 U.S.C. § 1983 (1982) provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

3. 42 C.F.R. § 431.220(a) (1984) provides in pertinent part:

> (a) The agency must grant an opportunity for a hearing to:
>
> (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness; and
>
> (2) Any recipient who requests it because he believes the agency has taken an action erroneously.

4. 42 C.F.R. § 431.241 (1984) provides:

> The hearing must cover—
>
> (a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility; and
>
> (b) Agency decisions regarding changes in the type or amount of services.

5. 42 C.F.R. § 431.246 (1984) provides:

> The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—
>
> (a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

6. 42 C.F.R. § 447.253(c) (1984) provides:

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

STATEMENT OF THE CASE

Plaintiff Coos Bay Care Center ("CBCC") is an intermediate care facility that provides long-term health care services for the developmentally disabled and the aged. (Findings and Recommendation, Pet. App. C at App-10). CBCC participates as a health care provider in Oregon's Medicaid program. (*Ibid.*). The individual plaintiffs are resident patients at CBCC. (J.A. at 3). Defendant Oregon Department of Human Resources ("DHR") is the Oregon agency responsible for administering the state's Medicaid program. (Findings and Recomendation, Pet. App. C at App-10). Defendant Richard C. Ladd is Administrator of the DHR division which directly administers Oregon's Medicaid program. (*Ibid.*).

Plaintiffs sued under 42 U.S.C. § 1983 (1982) on their own behalf and on the behalf of others similarly situated. They sought damages, injunctive and declaratory relief and certification as a class action. Plaintiffs alleged that defendants erroneously failed to classify certain patients (including the individual plaintiffs) as "heavy cost" care patients and, accordingly, failed to reimburse plaintiff CBCC at the special rate applicable under Oregon's Heavy Cost Program for care of those patients. (J.A. at 5).

Oregon's Heavy Cost Program is defined narrowly by state administrative rules. To be eligible, patients must be functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility

in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b). The heavy cost reimbursement rate is expressly identified as an "add-on to the facility's established rate for the clients' level of care." Or. Admin. R. 411-70-030(7)(b).[2]

A facility's basic reimbursement rate for care provided to all patients under Oregon's Medicaid program is determined under the provisions of a separate administrative rule that defines an all-inclusive rate for "all services, supplies and facility equipment required for care." Or. Admin. R. 411-70-085(1).[3] Oregon's Medicaid plan establishes the 75th percentile as the rate that reasonably will reimburse an efficiently and economically operated facility. Or. Admin. R. 411-70-440(2).[4] Under Oregon's plan, if a facility's claimed costs for providing services included in the all-inclusive or established rate fall within the lower 75 percent of costs incurred by all eligible facilities, Oregon reimburses the facility for all of its claimed costs. If its claimed costs are greater than the costs incurred by those within the lower 75th percentile, Oregon reimburses the facility only at the 75th percentile rate.

The "established rate" in Oregon's Medicaid plan thus is the reimbursement rate that the state has found will adequately reimburse efficiently operating facilities for services provided to Medicaid patients. The special add-on "heavy cost" reimbursement rate provides complete reimbursement

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[2] Or. Admin. R. 411-70-030(1) and (7) are set out in full in Pet. App. F at App-39.

[3] Or. Admin. R. 411-70-085(1) and (2) are set out in full in Pet. App. G at App-41.

[4] Or. Admin. R. 411-70-440 is set out in full in Pet. App. H at App-43.

through a special daily rate for services provided to patients who meet the requirements of the Heavy Cost Program.

Plaintiffs' complaint alleged that certain patients who qualify under the state's Heavy Cost Program have been denied eligibility for that program. (J.A. at 5-6). Plaintiffs alleged that defendants' failure to treat certain patients as "heavy cost" patients breached the provider contract, violated state law, and violated the provider's and patients' rights under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1982).

The case was assigned to a United States Magistrate for findings and recommendations. The magistrate determined that 42 U.S.C. §§ 1396 *et seq.* did not create enforceable rights or a private right of action and that plaintiffs, therefore, could not sue under 42 U.S.C. § 1983. The District Court of Oregon adopted the magistrate's findings and recommendation and dismissed plaintiffs' complaint with prejudice and without leave to amend. The court entered judgment for defendants.

Plaintiffs appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit held that plaintiffs' complaint alleged a violation of federal statutory rights cognizable under 42 U.S.C. § 1983. The court, therefore, reversed and remanded for further proceedings. On certiorari review by this Court, petitioners seek reversal of the Ninth Circuit's decision.

SUMMARY OF ARGUMENT

The Ninth Circuit has held that 42 U.S.C.§ 1983 provides a vehicle for federal judicial oversight of every aspect of a state's administration of its Medicaid program. This conclusion would expand dramatically federal court jurisdiction to review state legislative and executive conduct in connection with cooperative state-federal funding programs. Yet the appeals court reached this result without any discussion of the nature of the federal legislation involved, the limits on federal

court jurisdiction, or the vital importance of state sovereign immunity in our federal system. These considerations should have been the starting point in the analysis.

"Cooperative federalism" programs such as Medicaid are essentially contracts wherein two sovereigns agree to a division of governmental power and responsibility with respect to an area of mutual concern. Congress proposes the terms of the contract in the act creating the program. States accept those terms by electing to participate. The extent of federal judicial supervision of state functions in cooperative programs is a critical term of the agreement because it defines federal jurisdiction and correspondingly reduces the Eleventh Amendment immunity of participating states. Congress, therefore, should indicate its intention to provide for federal court enforcement of such an act in unmistakable terms in the act itself.

The appeals court ignored these basic federalism issues because it construed this Court's decision in *Maine v. Thiboutot* to hold that 42 U.S.C. § 1983 provides a remedy for any violation of federal law by state officials. However, this Court has always recognized that the threshold inquiry in any suit to enforce an act of Congress is whether the federal law creates the enforceable statutory rights asserted by the plaintiffs. Because the effect of recognizing federal statutory rights in the context of "cooperative federalism" programs is to define the scope of federal judicial oversight, the federal rights analysis should be guided by principles of federalism.

Plaintiffs contend that the Medicaid Act creates a federal statutory right to have individual provider reimbursement decisions measured against a federal standard. Nothing in the Medicaid Act remotely says this. Furthermore, recognition of a federal right to a specific level of provider reimbursement would be inconsistent with the history, purpose, and structure of the Medicaid Act.

The Medicaid Act specifies that provider reimbursement is to be made according to payment rates set by the states. These rates are to be "determined in accordance with methods and standards developed by the states." 42 U.S.C. § 1396a(a)(13)(A). The Act sets forth objectives that states are to consider in fixing rates; it does not provide a standard for evaluating individual reimbursement decisions.

The current state-controlled reimbursement scheme is the product of years of congressional and administrative trial and error. As originally enacted, the provisions of the Medicaid Act and its implementing regulations encouraged states to reimburse providers according to national Medicare rates. The use of a national standard proved inflationary and inefficient. Therefore, in 1980 Congress deliberately chose to make reimbursement standards a matter of state law.

The entire thrust of the Medicaid scheme is to leave the development of provider reimbursement rates, the administration of reimbursement programs and the review of individual reimbursement decisions to the states. The guiding principle is that medical costs can be managed more effectively through decentralized state control. The Act is designed to facilitate diversity in reimbursement levels from state to state. This overall purpose would be frustrated by recognition of a judicially enforceable national reimbursement standard.

The availability of federal judicial review for each state's provider reimbursement decisions would encourage forum shopping, duplicative actions and inconsistent adjudications. Such review would run counter to the basic structure of the Act. Federal law provides for *state* administrative appeals of reimbursement decisions precisely because those decisions are governed by state law. It makes no sense to recognize an alternative federal forum for such appeals because Congress

has provided no meaningful standard of review for federal courts to apply.

The Ninth Circuit's decision is wrong because Congress did not express or even hint at an intention to create federal provider reimbursement rights. The effect of the court's decision is to undermine substantially the basic principles of federalism and state sovereign immunity embodied in the Eleventh Amendment. Those principles should have constrained the Ninth Circuit's construction of the Medicaid Act. Notwithstanding this Court's Eleventh Amendment jurisprudence, the appeals court directed the trial court to entertain an action for retroactive and prospective relief against a state.

This Court has never permitted Congress to erode state immunity by innuendo. Clearly it should not countenance such erosion when the entire statutory scheme demonstrates a contrary intention.

ARGUMENT

I. Introduction.

At its core, this case graphically illustrates principles that are basic to state-federal relations and to the jurisdiction of the federal courts. However, the well-settled rules that control this case have been obscured by the dizzying amalgam of state and federal statutes under which it arises. The complex provisions of the Medicaid program, 42 U.S.C. §§ 1396 *et seq.*, may readily explain the analytic disorientation that characterizes the opinion of the Ninth Circuit. But the result reached by the appeals court is so at odds with precedent and common sense that it should have signaled the court to retrace its steps to find where it made a wrong turn.

Plaintiffs sued the State of Oregon, one of its agencies and one of its officials in federal court, in connection with the administration of the state's Medicaid plan. They sought to

recover money damages as well as declaratory and injunctive relief. Their claim relates to the state's alleged failure to make "specific and complete reimbursement" to CBCC for its provision of "heavy cost care." Both the concept of "heavy cost care" and the formula according to which such care is to be reimbursed are creatures of state law. State administrative rules define "heavy cost" reimbursement as an "add-on" to the state's established Medicaid rate. No federal statute or regulation even mentions the program or the concept of "heavy cost care."

The Ninth Circuit held that the plaintiffs' complaint stated a claim under 42 U.S.C. § 1983. (Pet. App. A at App-5). In an astonishing vault of logic, the court reached this result without any mention of its plain inconsistency with innumerable prior decisions of this Court. The appeals court thus recognized a § 1983 action commenced directly against a state in federal court, although this Court has held that the Eleventh Amendment bars federal courts from entertaining suits for retrospective and prospective relief against a state. *Edelman v. Jordan*, 415 U.S. 651 (1974). The lower court permitted Oregon's participation in the Medicaid program to subject the state to federal court jurisdiction without a state waiver or congressional abrogation of Eleventh Amendment immunity, despite this Court's repeated holding that such waiver or abrogation must be clearly expressed. *Welch v. Texas Dept. of Highways and Public Transportation*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5046, 5047 (June 25, 1987); *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985). And the appeals court found that federal jurisdiction exists in this case, although plaintiffs' claim is that the state has failed to make "heavy cost" reimbursement as provided by *state* law. It is axiomatic, however, that state-law-based claims do not provide a basis for federal jurisdiction. *See Gully v. First National Bank in Meridian*, 299 U.S. 109 (1936);

See also Pennhurst State School and Hospital v. Halderman, 465 U.S. 89, 120 (1984) (*Pennhurst II*) (Eleventh Amendment bars federal court adjudication of pendent state law claims against state officials).

The Ninth Circuit's decision completely ignored the building blocks of federalism that this Court has so carefully quarried. Relying exclusively upon *Maine v. Thiboutot*, 448 U.S. 1 (1980) (*Thiboutot*), the appeals court summarily concluded that 42 U.S.C. § 1983 is available "to compel participating states to comply with the provisions of the Social Security Act." (Pet. App. A at App-2). For the Ninth Circuit, plaintiffs' claims are invested with an overarching "federalness" merely because they arise in the Medicaid context. The appeals court held that this fact simultaneously confers federal jurisdiction, creates federal rights, and abrogates Eleventh Amendment immunity.

The result in this case stands cooperative federalism on its head and turns all cooperative funding programs into coercive vehicles of federal dominance. *Thiboutot*, read in context with other decisions of this Court, should not be interpreted to require this result. Last term, in *Welch v. Texas Dept. of Highways and Public Transportation*, *supra*, the Court reiterated the importance of federalism principles in determining whether a claim against a state is properly before it:

> We have been unwilling to infer that Congress intended to negate the state's immunity from suit in federal court, given the vital role of the doctrine of sovereign immunity in our federal system. . . . Moreover, the courts properly are reluctant to infer that Congress has expanded our jurisdiction.

55 U.S.L.W. at 5048. Cases decided subsequent to *Thiboutot* demonstrate that these same considerations should guide the determination whether the provisions of a state-federal cooperative funding statute, such as Medicaid, are enforceable against the states in federal court under 42 U.S.C. § 1983. *See*

Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981) (*Pennhurst I*); *Middlesex County Sewerage Authority v. National Sea Clammers Association*, 453 U.S. 1 (1981) (*Sea Clammers*).

Cooperative funding programs essentially are contracts between states and the federal government. Through these programs, two sovereigns agree jointly to fund and administer programs for the public welfare. If every aspect of these programs automatically is enforceable in federal court, then states are required to subject themselves and their programs to federal judicial supervision as the price of admission to the cooperative funding program. If Congress intends to extract such a price, it should say so plainly. When it has not clearly expressed such an intention, courts should not infer it.

The Ninth Circuit concluded that *Pennhurst I*, *supra*, and *Sea Clammers*, *supra*, merely narrowed *Thiboutot* "as applied to some federal statutes. . . ." (Pet. App. A at App-2). In doing so, the appeals court ignored the guidance that those cases provide as to the meaning and application of *Thiboutot*. The appeals court's approach to this case is thereby seriously flawed.

42 U.S.C. § 1983 does not create a cause of action for *every* violation of *every* federal statute. *Pennhurst I*, *supra*. It confers a remedy for deprivations (made under color of state law) of "*rights, privileges, or immunities* secured by the Constitution and laws" of the United States. Therefore, the relevant inquiry is not whether the plaintiffs' claim involves federal law, but whether the federal law involved creates rights, privileges or immunities.

In effect, the court of appeals has held that Title XIX of the Social Security Act confers upon Medicaid providers and patients alike a generalized right to Medicaid funding and reimbursement. This right embraces every detail of every federal statute and administrative regulation pertaining to the

Medicaid program, no matter how it is phrased, to whom it is directed or what it concerns. Apparently, the right also embraces every state regulation adopted in connection with the cooperative program. In the context of state-federal cooperative funding programs, the result of this holding is to take away through 42 U.S.C. § 1983 all of the protection against federal judicial intervention that principles of federalism provide.

This case turns on whether Congress intended the Medicaid Act to convert state plan provisions, adopted consistent with the general objectives of the Act, into federal statutory rights, enforceable against the states. In a federal system in which the composition and structure of Congress is itself relied upon "to insulate the interests of the states," *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 551 (1985) (*Garcia*),[5] the Court should not infer such an intent from congressional silence. As with abrogation of Eleventh Amendment immunity, the Court should require that congressional intent to create enforceable statutory rights in cooperative funding acts be expressed in "unmistakable language in the statute itself." *Atascadero State Hospital v. Scanlon*, 473 U.S. at 243.

The Medicaid Act cannot be construed to create provider reimbursement rights enforceable against the states in federal

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[5] In *Garcia*, the Court placed special reliance on Congress' concern and deference for state sovereignty. Justice Blackmun, writing for the Court, observed:

> Apart from the limitation on federal authority inherent in the delegated nature of Congress' Article I powers, the principal means chosen by the Framers to ensure the role of the States in the Federal system lies in the structure of the Federal Government itself. It is no novelty to observe that the composition of the Federal Government was designed in large part to protect the States from overreaching by Congress. . . .

469 U.S. at 550.

court. Nothing in the Medicaid Act remotely suggests congressional intent to create such rights. To infer their existence would contradict the language, history, purpose and structure of the Act. Moreover, such a construction of the Medicaid Act would directly conflict with the Eleventh Amendment, which stands as a bar to federal judicial review of the claims asserted.

II. Title XIX of the Social Security Act Does Not Create Any Federal Rights That Are Implicated in This Case.

A. *Maine v. Thiboutot* and the Federal Rights Analysis.

The Ninth Circuit's decision badly mangles basic federalism principles because it reads more into *Maine v. Thiboutot* than is there. This Court has always held that federal statutes are enforceable through private actions *only* to the extent that they create rights personal to the plaintiff. *Thiboutot* does not alter that rule. *Thiboutot* holds that 42 U.S.C. § 1983 creates a cause of action for deprivation (under color of state law) of any federal statutory *right*. The Court rejected arguments by the State of Maine and various amici that § 1983 was intended to provide a remedy only for violation of constitutional rights and of laws enacted pursuant to section 5 of the Fourteenth Amendment to protect those rights.[6]

Prior to *Thiboutot*, both this Court and lower courts sometimes assumed that § 1983 was available to remedy violations of rights created in non-civil rights stat-

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[6] 448 U.S. at 6-7. *See* Brief for Petitioners, 10-18; Brief Amici Curiae for the Commonwealth of Pennsylvania and the States of New Hampshire, New Jersey, Rhode Island, Vermont and Delaware, 4-9. *See also Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600, 623 (1979) (Powell, J., concurring).

utes.[7] However, the principal inquiry in suits to enforce acts of Congress was whether the act included either express or implied authorization for private enforcement. It mattered little that a federal statute created *substantive* rights, if Congress had not authorized a *procedure* to vindicate those rights. Thus, in *Cort v. Ash*, 422 U.S. 66 (1975) and its progeny, the Court employed a four-factor analysis to determine whether Congress intended to create an implied private right of action to enforce a federal statute.[8] Through this

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[7] *See, e.g., Miller v. Youakim*, 440 U.S. 125 (1979) (Aid to Families with Dependent Children Foster Care Program); *Edelman v. Jordan*, 415 U.S. 651 (1974) (Aid to Aged, Blind and Disabled); *Hagans v. Lavine*, 415 U.S. 528 (1974) (Aid to Families with Dependent Children); *Louise B. v. Colautti*, 606 F.2d 392 (3d Cir. 1979) (Aid to Families with Dependent Children); *Tongal v. Usery*, 601 F.2d 1091 (9th Cir. 1979) (Emergency Unemployment Compensation Act of 1974); *Blue v. Craig*, 505 F.2d 830 (4th Cir. 1974) (Medicaid); *Gomez v. Florida State Employment Service*, 417 F.2d 569 (5th Cir. 1969) (Wagner-Peyser Act of 1933).

No Supreme Court decision prior to *Thiboutot* held that § 1983 applied to non-civil rights statutes. The rule was assumed in the course of disposing of other questions. *Maine v. Thiboutot*, 448 U.S. at 31 (Powell, J., dissenting). Some lower courts had refused to extend the reach of § 1983 beyond the protection of Fourteenth Amendment rights. *See, e.g., McCall v. Shapiro*, 416 F.2d 246, 249-50 (2nd Cir. 1969); *Wynn v. Indiana State Department of Public Welfare*, 316 F.Supp 324, 330-33 (N.D. Ind. 1970).

[8] The Court explained:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff "one of the class for whose *especial* benefit the statute was enacted," . . . that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? . . . Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? . . . And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Cort v. Ash, 422 U.S. 66, 78 (1975) (citations omitted, emphasis in original). *See also Touche Ross and Co. v. Redington*, 442 U.S. 560 (1979); *Davis v. Passman*, 442 U.S. 228 (1979); *Cannon v. University of Chicago*, 441 U.S. 677 (1979); *Chrysler Corporation v. Harold Brown*, 441 U.S. 281 (1979).

implied right of action analysis, consideration of the nature of substantive federal rights was subsumed in the search for an enforcement vehicle.

Under *Cort v. Ash*, whether the inquiry was made in the context of suits between private parties,[9] against federal officials,[10] or against persons acting under color of state law,[11] the decision to imply a private right of action largely was based on whether Congress intended to create rights personal to the plaintiff. As the Court noted in *Cannon v. University of Chicago*, 441 U.S. 677 (1979), with only one exception,

> this Court has never refused to imply a cause of action where the language of the statute explicitly conferred a right directly on a class of persons that included the plaintiff in the case. . . . [c]onversely, the Court has been especially reluctant to imply causes of action under statutes that create duties on the part of persons for the benefit of the public at large.

441 U.S. at 690 n. 13.

After *Maine v. Thiboutot*, 42 U.S.C. § 1983 provides a prefabricated enforcement vehicle for violation of federal statutory rights under color of state law. Therefore, when § 1983 is available, it is unnecessary to determine whether there is an implied right of action in a substantive act of Congress.[12] Nevertheless, both before *Thiboutot*, (*see, e.g., Cannon v. University of Chicago, supra,*) and after (*see, e.g.,*

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[9] *See, e.g., Santa Fe Industries, Inc. v. Green*, 430 U.S. 462 (1977).

[10] *See, e.g., Chrysler Corporation v. Harold Brown*, 441 U.S. 281 (1979).

[11] *See, e.g., Middlesex County Sewerage Authority v. National Sea Clammers*, 453 U.S. 1 (1981).

[12] The complaint in this case alleges the existence of a cause of action directly under 42 U.S.C. § 1396a as well as under 42 U.S.C. § 1983. (J.A. at 8). The assertion of an implied private right of action under the Medicaid Act is superfluous. Plaintiffs have no implied right of action under the Medicaid Act unless the Act confers federal rights on them, *Cort v. Ash, supra.* If the Act in fact confers those rights, 42 U.S.C. § 1983 provides a remedy unless the *express* remedial scheme in the statute is exclusive. *See Sea Clammers*, 453 U.S. at 20-21 (1981).

Pennhurst I, supra,) a federal statute will support a claim for relief *only* if Congress intended for the statute to confer the personal rights asserted in the claim.

Thus, to determine whether plaintiffs have alleged an enforceable claim, the Court first must identify the specific federal rights that plaintiffs contend defendants have violated (II, B). The Court must then examine the Medicaid Act itself, to determine whether it confers those rights. The language of the Medicaid Act (II, C) does not remotely suggest the creation of the rights plaintiff's assert. Moreover, the Act's history (II, D), purpose (II, E), and structure (II, F) would be undermined by recognition of those rights. More fundamentally, the Ninth Circuit's misapplication of the federal rights analysis led it directly to controvert the basic principles of federalism embodied in the Eleventh Amendment (III).

B. Alleged Federal Statutory Rights.

The Ninth Circuit did not identify the federal statutory rights asserted by the plaintiffs or explain how those rights allegedly were violated. The task is difficult because the complaint has a chameleon-like quality. The scant factual allegations take on an appearance of federal significance only because they are cast against the background of a state-federal program. Yet, upon close examination, there is little in the complaint to indicate what action by defendants violated what alleged federal rights.

The most common sense reading of the complaint suggests that defendants have refused to provide the special add-on heavy cost reimbursement to Coos Bay Care Center for patients who purportedly qualify for it under *state* law and under the state's Medicaid plan.[13] The complaint appears to

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[13] Plaintiffs' complaint alleges:

> In spite of the qualification of the patients, the State of Oregon and Defendant Richard C. Ladd, acting under color of state law,

(Footnote continued on next page)

allege a claim arising under state law and under the provider contract between CBCC and the State of Oregon. Plaintiffs allege, however, that the conduct "violates 42 U.S.C. § 1396a *et seq.* and 42 C.F.R. § 447.252." (J.A. at 8). Thus, plaintiffs appear to contend that there is a federal statutory right to absolute compliance with every provision of state law relating to the state's participation in the Medicaid program.[14] Cast in its starkest terms, this assertion means that every administrative error by state officials in connection with their administration of the state Medicaid plan would implicate federal rights and would give rise to a federal cause of action under 42 U.S.C. § 1983. However, *sub silentio* conversion of every provision of state law into a federal right would be a dramatic step for Congress to take. Given the traumatic effect on state-federal relations that such a requirement would cause, the intent to "federalize" state law should be expressed plainly.

In their Brief in Opposition to Certiorari, plaintiffs appear to suggest that a more modest claim is intended. They now read their complaint to allege that the state's administration

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> have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients to and on behalf of the Plaintiffs. . . .

(J.A. [illegible] 6).

[14] Plaintiffs also claimed that the denial of heavy cost reimbursement constituted a taking of property without due process or just compensation. *See* J.A. at 6. Apart from whatever entitlements are conferred under the terms of the Medicaid Act itself, plaintiffs have no protected interest in a particular level of provider reimbursement entitling them to process or compensation before the government can reduce their reimbursement. *Cf. Bowen v. Gilliard*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5079 (June 25, 1987) (welfare benefit recipients do not have a property interest in a particular level of benefits; statutory changes in their entitlements therefore do not result in a taking). Those allegations accordingly did not provide an independent basis for relief. This undoubtedly explains why neither the district court nor the Ninth Circuit addressed these claims.

of its Medicaid plan does not "comply with *federal* law." (Br. in Opposition to Cert. at 4) (emphasis in original). By this, plaintiffs presumably mean that federal law creates a right to reimbursement according to a certain defined federal standard and that, in specific instances, Oregon's reimbursement practices fail to satisfy that standard.[15] This assertion also has broad ramifications. If there is a federal statutory right to have individual state provider reimbursements measured against a federal standard, then every provider payment, by every state participating in the Medicaid program, is a potential federal cause of action under 42 U.S.C. § 1983. This broad sweep of potential federal judicial supervision is so at odds with the states' traditional immunity from suit in federal court and would so greatly expand the scope of federal jurisdiction, that Congress should express the creation of such a federal right in "unmistakable language." *Atascadero State Hospital v. Scanlon*, 473 U.S. at 243.

Regardless how the complaint is read, it alleges broad new federal statutory rights that this Court never has recognized. Therefore, we must examine the Medicaid Act and its implementing regulations to identify the source of the rights asserted.

C. The Language of the Medicaid Act.

No terms in the Medicaid Act or its implementing regulations embody a provider right to reimbursement at a particular level. The Medicaid Act creates a cooperative state-federal

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[15] The Ninth Circuit appears to have assumed that this was plaintiff's claim. In the last paragraph of its opinion, the circuit court offered the following guidance to the district court and to the parties as to how plaintiffs' claim is to be evaluated:

> To prevail on the merits, plaintiffs must convince the trial court that the actions and non-action of the State of Oregon violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A).

(Pet. App. A at App-5).

mechanism to provide medical assistance, rehabilitation and other services to eligible persons through a program administered by participating states. Exercising its spending power under article I, section 8, clause 1 of the United States Constitution,[16] Congress annually appropriates money for the matching fund program, pursuant to the authorization contained in 42 U.S.C. § 1396. Plaintiffs' complaint allegedly is based, in part, on § 1396, but that statute provides:

> For the purpose of enabling each State, *as far as practicable under the conditions in such State*, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. *The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, . . . State plans for medical assistance.*

(Emphasis added). Thus, states that opt for Medicaid participation must develop detailed plans for administration of the state medical assistance program. Those plans must be approved by the Secretary of Health and Human Services before federal funds are disbursed. 42 U.S.C. § 1396a(a) details what the state plan for medical assistance must include.

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[16] The Medicaid Act was first enacted in 1965 as Sec. 121 of Pub. L. 89-97. The Act added Title XIX to the Social Security Act (codified at 42 U.S.C. §§ 1396 *et seq.*). The Social Security Act is a valid exercise of Congress' power under article I, § 8 of the United States Constitution, to lay and collect taxes to provide for the general welfare. *See Helvering v. Davis*, 301 U.S. 619 (1937); *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937); *Carmichael v. Southern Coal Co.*, 301 U.S. 495 (1937).

In their complaint, plaintiffs invoke subsection (13)(A) of 42 U.S.C. § 1396a(a). That subsection specifies that a state plan for medical assistance must provide:

> for payment . . . of the . . . intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state . . .) . . . *which the state finds*, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards and to assure that individuals . . . have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

Plaintiffs also rely upon regulations[17] adopted by the Health Care Financing Administration (HCFA) to implement 42 U.S.C. § 1396a(a). Like the statute, HCFA's implementing regulations merely identify general objectives that the state-developed provider reimbursement rates are to serve.[18] HCFA's regulations also require that participating

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[17] This Court has never considered whether administrative regulations alone can create rights enforceable under 42 U.S.C. § 1983. *See Wright v. City of Roanoke Redevelopment and Housing Authority*, ___U.S. ___, 107 S.Ct. 766, 778 (1987) (O'Connor, J., dissenting).

[18] 42 C.F.R. § 447.253 (1984) provides in pertinent part:

> (a) *State assurances.*. In order to receive HCFA approval of a significant State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.
>
> (b) *Findings.* Whenever the Medicaid agency makes a significant change in its methods and standards, but not less often than annually, the agency must make the following findings:

(Footnote continued on next page)

states provide an appeals procedure through which providers may obtain review of state-established reimbursement rates. 42 C.F.R. § 447.253(c) (1984).

In sum, 42 U.S.C. § 1396a and its implementing regulations merely require participating states to develop reimbursement rates, *according to state standards and methods*, that *"the state finds"* are reasonable and adequate to meet specified ratemaking criteria. Participating states also are required to provide for "prompt administrative review" of provider chal-

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(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

. . . .

(2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) *Uniform cost reporting.* The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) *Audit requirements.* The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) *Public notice.* The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) *Rates paid.* The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

lenges to the adequacy of those rates. Plaintiffs contend that these provisions of federal law entitle them to obtain federal judicial review of provider reimbursement decisions made at the state level. Plaintiffs are wrong. These provisions neither create nor signal personal rights to a particular level of reimbursement.

The words used in a statute are crucial in determining the statute's legal effect. When Congress intends to confer personal rights, it is capable of using words that clearly express its purpose and fully describe the entitlement created.[19] Moreover, the presence or absence of congressional intent to confer rights is irrelevant if Congress does not *promulgate* that intent through the words of a statute. *See* L. TRIBE, CONSTITUTIONAL CHOICES 30-31 (1985). Thus, an act that provides that "[a]ll persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, privileges, advantages and accommodations of any place of public accommodation. . ." 42 U.S.C. § 2000(a) (1982), clearly embodies a declaration of personal rights. An act which provides that "[n]o person shall sell, or offer for sale colored oleomargarine . . . unless . . . it is clearly labeled as margarine," 21 U.S.C. § 347 (1982), may just as clearly benefit consumers, but the prohibitory language indicates Congress' intent to create a duty for the benefit of the public at large, rather than a desire to confer individual entitlements. *See Cannon v. University of Chicago*, 441 U.S. at 690 n. 13. The Medicaid Act provisions upon which plaintiffs rely fall into this second category.

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[19] *See Cannon v. University of Chicago*, 441 U.S. at 690 n. 13; *Schwegmann Brothers v. Calvert Distillers Corp.*, 341 U.S. 384, 395 (1951) (Jackson, J., concurring). As Justice Jackson later observed, statutory interpretation must proceed "by analysis of the statute instead of by psychoanalysis of Congress." *United States v. Public Utilities Commission*, 345 U.S. 295, 319 (1953) (Jackson, J., concurring). *See generally* L. TRIBE, CONSTITUTIONAL CHOICES 30-31 (1985); Frohnmayer, *Of Legislative Intent, The Perils of Legislative Abdication and the Growth of Administrative and Judicial Power*, 22 WILLAMETTE L. REV. 219 (1986).

Plaintiffs contend that 42 U.S.C. § 1396a(a)(13)(A) creates a right to provider reimbursement at a particular level,[20] as determined pursuant to a federal standard. Alternatively, they contend that Congress intended to make strict compliance with state Medicaid laws a matter of federal statutory right. It would require unbelievable distortion of the statutory language to convert that section from a requirement that the state pursue certain objectives in developing provider reimbursement rates, to a requirement that each reimbursement decision be measured against the broad goals of the statute. The statute provides no standards applicable to state reimbursement practices; it sets forth objectives which the

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[20] Plaintiffs in this case include persons acting as guardians ad litem on behalf of patients who are alleged to qualify as "heavy care" patients under the Oregon Heavy Cost Program. The complaint includes class action allegations whereby these plaintiff patients seek to represent all other "heavy care" patients. (J.A. at 6-7). The only operative facts alleged with respect to the patient claims in this case are:

> [T]he plaintiffs' wards . . . and the class they represent do not receive the quantity or quality of care guaranteed to them constitutionally and by state and federal laws, statutes, and regulations and as aforesaid, although Plaintiff Coos Bay Care Center does afford "heavy care" patients as much "heavy care" as possible.
>
> Throughout the State of Oregon there are other heavy care patients residing within long term health care facilities who similarly qualify for heavy care but who do not receive the full amount of appropriate care because of the refusal of the Defendants to appropriately reimburse health care providers for such care.

(J.A. at 6).

Thus, the plaintiff patients allege that private long-term health care facilities are failing to provide adequate care to patients because the state is violating the *provider's* right to adequate reimbursement. The plaintiff patients do not allege any other breach of rights by the state, they merely allege that they are being harmed by that breach. While their allegations of injury *may* give the patients standing to assert the provider's right to reimbursement, *see, e.g., Simpson v. Heckler*, 630 F. Supp. 736 (E.D. Pa. 1986); *Thomas v. Johnston*, 557 F.Supp. 879, 902-04 (W.D. Tex. 1983), they do not add anything to the substantive claims in this case. Whatever recourse the patients may have against health care facilities which fail to provide adequate care, their presence in this case does not create a federal right to a particular level of provider reimbursement, where none otherwise exists.

state is to consider in *fixing rates*. Reimbursements are governed by rate, not by the generalized goals of the statute. In fact, to the extent that the section contemplates that provider reimbursement will itself measure up to a specified standard, the section leaves the development of that standard to the states. The section expressly provides that payment rates are to be "determined in accordance with methods and standards developed by the states." The Ninth Circuit concluded that it was the province of the federal district court to determine whether the actions and nonactions of the state (in making provider reimbursement) violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A). The words of the statute directly contradict this conclusion.

The recognition of personal statutory rights in the context of cooperative state-federal funding programs has significant effect on the balance of power between the governmental partners in the program. *Pennhurst I, supra.* As noted above, principles of federalism warrant requiring Congress to create those rights through "unmistakable language" *See Welch v. Texas Dept. of Highways and Public Transportation*, 55 U.S.L.W. at 5048 (quoting *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 243 (1985)). At a minimum, basic principles of legislative interpretation require that Congress create those rights through operative language. Congress has not done so here.

Furthermore, even when Congress has used "rights" language in a statute, that fact is not necessarily controlling. In *Pennhurst I, supra*, for example, the Court held that the "bill of rights" provision of the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000 *et seq.* (1976 ed. and Supp. III), did not create substantive statutory rights, enforceable against the states. The legislative history and overall structure of the Act indicated only that Congress intended "to encourage, rather than mandate,

the provision of better services to the developmentally disabled." 451 U.S. at 20. The Court declined to give literal effect to provisions in the Act in which Congress made "findings respecting the rights of persons with developmental disabilities," 42 U.S.C. § 6010, primarily because, in the context of the cooperative state-federal funding program at issue in the case, treating Congress' findings as personal rights would impose "congressional policy on a state involuntarily." 451 U.S. at 16. The parts of the Medicaid Act relied upon by plaintiffs contain no language that effectively embodies the privileges allegedly created; indeed, the legislative history and overall structure of the Act refute plaintiffs' contentions.

D. The Legislative History of 42 U.S.C. § 1396a(a)(13)(A).

The provider reimbursement provisions contained in 42 U.S.C. § 1396a(a) and its implementing regulations are the culmination of a consistent legislative trend away from centralized, federal control of provider reimbursement standards and practices and toward greater delegation of reimbursement responsibility to participating states. The current reimbursement provisions, enacted in 1980,[21] are the product of congressional and administrative trial and error since the Medicaid Act became law in 1965.[22] As their history demonstrates, they are the product of a conscious and informed congressional decision to leave the development of provider reimbursement rates, the administration of reimbursement programs, and the review of individual reimbursement decisions to the state participants in the joint state-federal Medicaid venture.

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[21] The Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962 (1980).

[22] Social Security Act Amendments of 1965, Pub. L. No. 89-97, Part 2, sec. 121 (1965).

As enacted in 1965, reimbursement standards were so general that states adopted either arbitrary flat rates or, more commonly, resorted to the rate methodology of the federal Medicare program. Costs spiraled, encouraging Congress to amend the Act in 1972. *See generally Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511 (5th Cir. 1983) and discussion therein; Preamble to Interim Final Rule for Medicaid Program; Payment for Long Term Care Facility Services, 46 Fed. Reg. 47,964 (1981). Under the 1972 language, states were to pay for intermediate care facility services "on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the state on the basis of cost finding methods approved and verified by the Secretary." 42 U.S.C. § 1396a(a)(13)(E) (1974). The change was intended to permit states to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable-cost formula. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 287-88 (1972). Congress therefore declined to mandate any particular formula for reimbursement, choosing instead to delegate to the states the responsibility to design their own methodologies subject to close federal administrative oversight.[23]

The 1972 amendments failed to achieve their basic cost-containment objectives. Equally problematic, they proved to be a disincentive to state flexibility. Complex HEW regulations and a rigorous federal approval process for alternative

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[23] The requirement in the 1972 amendments that the Department of Health, Education and Welfare (HEW) "approve and verify" each state's cost finding method led the agency to adopt a series of complex regulations governing state reimbursement practices. For example, HEW promulgated detailed regulations prescribing definitive upper and lower limits on the acceptable range of "reasonable costs." 42 C.F.R. §§ 450.30(a)(3)(iv)(A), 450.30(b)(6) (1977). *See also* 41 Fed. Reg. 27,300 at 27,301-04 (1976) and 43 Fed. Reg. 4,861 at 4,862 (1978). Significantly, HEW accepted as part of its obligation under the statute the responsibility to review and approve the state's methods for rate-setting and cost-finding, and also "to assure that the methodologies *in fact* result in reasonable cost-related reimbursement." 41 Fed. Reg. at 27,300 (emphasis added).

state reimbursement methodologies mired the states in a bureaucratic bog of red tape and administrative paperwork. States generally were forced to abandon their attempts to devise alternative reimbursement systems and to adhere instead to Medicare reimbursement principles, which met with automatic approval. *See* Senate Finance Comm. S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979). Both of these results defeated the purpose of the 1972 amendments. Congress had intended neither to subject the states to administratively burdensome federal review, nor to have them follow as a matter of course the inherently inflationary Medicare principles which provided no incentive for efficient performance. *Ibid. See also* 46 Fed. Reg. at 47,965-66. Accordingly, in 1980, Congress amended the Medicaid Act in a more radical way.

The 1980 changes, which resulted in the statute's current reimbursement provisions, altered fundamentally the allocation of responsibility and authority for reimbursement rate-setting and review as between the states and the federal government. The amendments delegated to the states the responsibility to develop methods and standards for setting reimbursement rates. Moreover, the 1980 provisions entrusted the states, not the federal government, with the responsibility to determine that the reimbursement rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. Again, as in 1972, the objective was to provide the states flexibility in developing methods of payment for their Medicaid programs in order to break away from the inflationary and cost-ineffective Medicare practices. *See* S. Rep. No. 471 at 28-29. This time, however, that objective was achieved by maximizing state discretion and responsibility for developing and admin-

istering state plans while minimizing federal administrative oversight and second-guessing.[24]

HCFA was well aware of Congress' objectives in amending the Medicaid Act in 1980 and promulgated its regulations accordingly. *See generally* 46 Fed. Reg. at 47,964-66. HCFA's regulations therefore echoed the language of the statute, directing the states to develop payment methods and standards and leaving it to the states to find that the rates are reasonable and adequate to meet the costs of efficient and economic providers. 42 C.F.R. § 447.252 (1981). Significantly, HCFA further mandated that each state agency develop a provider appeals process. 42 C.F.R. § 447.258 (1981). The federal agency defended the requirement as desirable because "individual facility rates will not receive Federal review under the revised regulations." 46 Fed. Reg. at 47,969. The federal agency was lobbied to provide national standards for Medicaid administration by defining terms such as "efficiently and economically operated facility" and by developing explicit criteria for federal review of states' methods and standards for establishing payment rates. But in responding to comments on its 1981 interim rules, HCFA declined to do so. It reasoned that federal restrictions on state discretion would be inconsistent with congressional intent.[25]

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[24] As stated in the Senate Finance Committee Report:

> The Congress expects that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

Id. at 29.

[25] For example, HCFA stated:

> We can appreciate the desire for explicit criteria for Federal review of States' methods and standards for establishing payment rates. However, we feel that such a list of criteria may be viewed as

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The history of the current provisions of the Medicaid Act serves to underscore the conclusion that Congress did not create an enforceable right for providers to be reimbursed at a federally prescribed level. After fifteen years of experimentation with federal reimbursement standards in an effort to control escalating costs, Congress settled upon a new allocation of responsibility for developing and administering provider reimbursement rates: Congress elected to make reimbursement standards a discretionary matter of state law.

E. Purpose of the Medicaid Act.

Congressional intent is the polestar in determining whether an Act of Congress creates personal rights. *Pennhurst I*, 451 U.S. at 15; *Cort v. Ash*, 422 U.S. at 78. A variety of factors aid in the determination of congressional intent. However, absent an express declaration of purpose either to confer or to withhold such rights, there are no magic incantations that, when included in a statute, mean that new personal rights necessarily flow from it.

> In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law and to its object and policy.

Pennhurst I, 451 U.S. at 18 (*quoting Philbrook v. Glodgett*, 421 U.S. 707, 713 (1975)).

The assessment of the "object and policy" of a congressional act must be guided by basic constitutional

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> imposing Federal standards for payment rates, an effect that would be contrary to legislative intent.

Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hospital Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

facts: Congress possesses only limited powers; its authority is constrained by the distribution of power among the branches of government and between the federal and state governments; and Congress' enumerated powers have at least as much to do with the regulation of individual conduct, the allocation of government power, and the funding and preservation of government operations as with the definition of individual liberties. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 5-1, at 224 (1978). Congress also must be charged with the knowledge that, because of 42 U.S.C. § 1983, the creation of federal statutory rights necessarily authorizes the enforcement of those rights against state officials in federal court. It is appropriate, therefore, when determining whether Congress intended to create a statutory right, to consider whether federal judicial oversight would tend to advance or to frustrate the overall purpose of the law.

Discovery of the specific constitutional authority relied upon by Congress in enacting legislation sheds considerable light on the "object and policy" of the Act in question. When, for example, Congress acts pursuant to section 5 of the Fourteenth Amendment to enforce constitutional rights, an intent to create enforceable statutory rights readily may be inferred. *See, e.g., Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976); *Oregon v. Mitchell*, 400 U.S. 112 (1970); *Katzenbach v. Morgan*, 384 U.S. 641 (1966). On the other hand, when Congress authorizes expenditures to provide for the common defense, there is no basis to conclude that Congress intended to create personal rights, even though specific individuals may benefit from its action. Between these two extremes, the legislative power source may be less definitive, but it nevertheless is significant evidence of congressional purpose.

The purpose of Spending Clause legislation such as the Medicaid Act can be discerned fairly easily from the terms and conditions that Congress attaches to its expenditure of public

moneys. As a constitutional matter, the expenditure must be for the "general Welfare," U.S. Const. art I, § 8, cl. 1, a stipulation which suggests, at least as a starting point, an orientation toward producing benefits for the public at large rather than creating special personal entitlements. *Cf.*, *Cannon v. University of Chicago*, 441 U.S. at 690 n. 13.

More importantly, when, as in the Medicaid program, Congress uses its spending power to create state-federal cooperative funding programs, this Court has pointedly emphasized the importance that Congress clearly state the conditions it attaches to participation in the program so that states may make an informed choice whether to participate. *Pennhurst I*, 451 U.S. at 17. As noted above, the effect of finding a congressional intent to create personal statutory rights is to subject state officials to potential liability under 42 U.S.C. § 1983, each time it is alleged that their conduct violated the terms of the federal statute. In the context of state-federal cooperative programs, recognition of personal statutory rights can subject large categories of state action to federal judicial review. This fact obviously is significant to the states in deciding whether to participate in the Medicaid program. Therefore, a determination that Congress intended to create personal rights through the provisions of the Medicaid Act should only be made upon the most unambiguous expression of such intent. As the Court noted in *Pennhurst I*:

> Unlike legislation enacted under § 5, however, legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the states agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the state voluntarily and knowingly accepts the terms of the "contract." . . . There can, of course, be no knowing acceptance if a state is unaware of the conditions or is unable to ascertain what is

> expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. . . . By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

451 U.S. at 17 (citations and footnotes omitted).

If Congress intended to create a personal right for providers to be reimbursed for Medicaid services at a particular level, according to a federal standard, it failed miserably to express that intent with a clear voice. In electing to participate in the Medicaid program, no state reasonably could have known that it was agreeing to subject every individual provider reimbursement decision to federal judicial review through 42 U.S.C. § 1983.

In fact, the entire thrust of the Medicaid Act and its scheme for provider reimbursement manifests Congress' objective to leave the development of provider reimbursement rates, the administration of reimbursement programs, and *the review of individual reimbursement decisions*[26] to the states. The principle underlying the Medicaid funding scheme is that medical costs can be managed more effectively through decentralized state-administered control. The statutory scheme contemplates and facilitates diversity in reimbursement practices and levels from state to state. It would be a peculiar sort of federal statutory right whose shape and substance varied so greatly from state to state, depending upon each state's level of commitment to the cooperative Medicaid program.[27]

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[26] 42 C.F.R. § 447.253(c) (1984).

[27] Ironically, recognition of a federal statutory right to a provider reimbursement level as specified in state Medicaid plans would have the greatest impact in those states with the most comprehensive Medicaid programs and the most detailed and ambitious reimbursement rate structure. The more thorough a state is in developing its rate structure, the greater would be the state's potential exposure to liability under 42 U.S.C. § 1983. The creation of such counterproductive incentive systems should not be attributed promiscuously to Congress.

Moreover, the reimbursement provisions in the Medicaid Act reflect at least as much concern with ensuring that provider payments are not unreasonably or unnecessarily *high*, as with guaranteeing that providers are adequately compensated for their efforts. Federal concern with controlling Medicaid costs is more than a mere nod to the fiscal problems of the state. Medicaid is largely funded by *federal* money. It is logical, therefore, for Congress to condition payments to state Medicaid programs on assurances that the money will be carefully spent.

The Act is replete with such conditions. For example, the state plan must provide methods and procedures to "safeguard against unnecessary utilization of such care and services . . . and to assure that payments are consistent with efficiency economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A). The state plan must provide regular prepayment and postpayment claims review "to ensure the proper and efficient payment of claims and management of the program." 42 U.S.C. § 1396a(a)(37)(B).[28]

In short, the Act requires states electing to participate in the Medicaid program to develop efficient provider reimburse-

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[28] HCFA regulations include provisions imposing upper limits on provider payments. 42 C.F.R. § 447.271 (1984) provides:

> (a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.
>
> (b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

42 C.F.R. § 447.253(b)(2) (1984) provides:

> (2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

ment rates and processes. The Act contemplates that states will contract with providers to accomplish the purposes of the Medicaid program and it requires the states to describe in their Medicaid plans the terms and conditions upon which they will do so. The Act contemplates that provider reimbursement will be governed by state law and by the terms of provider contracts. As noted above, Congress did not express, or even hint at, an intent to create federal provider reimbursement rights. Equally important, recognition of such rights would undermine the basic purpose of the Act.

F. The Structure of the Medicaid Act.

The foregoing arguments establish that the existence of a federal statutory right to provider reimbursement would be inconsistent with the language, the history and the purpose of the Medicaid Act. There are also deeper factors, relating to the nature of state-federal relations, that caution against recognition of federal statutory rights in the context of "cooperative federalism" programs.[29] However, the consequences of the Ninth Circuit's holding that plaintiffs have a federal claim under 42 U.S.C. § 1983 are not entirely theoretical.

The availability of federal judicial review of each state's provider reimbursement decisions, under different, state-established rates, potentially could leave the lower federal courts awash in complex, data-intensive provider appeals. The availability of § 1983 as an alternative remedy to the federally mandated state administrative procedures would encourage forum shopping, duplicative actions and inconsistent adjudications. These practical problems would arise largely from the fact that § 1983 actions challenging provider reimbursement decisions run counter to the basic structure of the Act.

In *Middlesex County Sewerage Authority v. National Sea Clammers Association, supra*, this Court held that 42 U.S.C.

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[29] *See* Part I, *supra* at p. 9-14, Part III, *infra* at p. 39-43.

§ 1983 could be foreclosed as a remedy for violation of statutory rights "[w]hen the remedial devices provided in a particular act are sufficiently comprehensive" as to demonstrate congressional intent to preclude § 1983 remedies. 453 U.S. at 20. In *Sea Clammers*, the Court assumed the existence of enforceable statutory rights and focused on the enforcement procedure included in the Federal Water Pollution Control Act itself as evidence of an implied withdrawal of other remedies. Although the Medicaid Act does not provide a comprehensive federal enforcement scheme for provider reimbursement, the Act comparably displaces a § 1983 remedy.

Consistent with its overall purpose of leaving the development and administration of provider reimbursement schemes to the states, the Medicaid Act directs that state Medicaid plans provide an administrative scheme for appeals by patients, 42 U.S.C. § 1396a(a)(3), and procedures for both prepayment and postpayment review of provider reimbursement claims, 42 U.S.C. § 1396a(a)(37)(B).[30] HCFA regulations require states to establish a procedure for provider appeals that allows individual provider challenges to state payment rates.[31] Congress' overt delegation of provider reimbursement review to the states is compelling evidence that

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[30] The fact that Congress directed states to provide for "fair hearings" to patients and for "claims review" of provider reimbursement claims is further evidence that Congress did not view health care providers as direct beneficiaries of the Act whose interests were deserving of special protection. *See Cannon v. University of Chicago*, 441 U.S. at 690, n. 13.

[31] 42 C.F.R. § 447.253(c) (1984). Although the federal regulation requires states to allow *administrative* review of provider appeals, Oregon law guarantees the availability of at least two levels of state court review, after the administrative proceeding. If plaintiffs had pursued their state remedies under the Medicaid program, their claim would have been reviewed by the state Medicaid agency. The agency decision would have been subject to review in the circuit (trial) court and then, by appeal, to the court of appeals. *See* Or. Admin. R. 461-09-000 (Fair Hearing Definitions); Or. Admin. R. 461-09-010 (The Hearing Request); Or. Admin. R. 461-09-011 (Group Fair Hearings); and Or. Admin. R. 411-70-435 (Provider Appeals). (Pet. App. I). *See also* Or. Rev. Stat. §§ 183.482 and 183.484 (Pet. App. J).

Congress considered the entire issue of reimbursement to be a matter of state concern, governed by state law, and administered exclusively by the states.

In this respect, *Sea Clammers* is directly analagous. Here, as in *Sea Clammers*, the nature of the remedial scheme prescribed in the substantive act indicates that Congress did not intend for 42 U.S.C. § 1983 to be available as a separate federal remedy.

It is entirely consistent with the nature of state-federal cooperative funding statutes for Congress to provide expressly that all or some aspects of the cooperative program will be administered *and reviewed* at the state, rather than the federal, level. Programs such as Medicaid essentially involve the allocation of government power and responsibility by agreement, between the participating governments. When, as in the case of provider reimbursement, the federal statute allocates to the states the power and responsibility to fix and administer rates, it follows logically that the responsibility to provide appropriate review of those rates also should be left to the states. If it can be said that the Medicaid statute creates "rights" to provider reimbursement, it is inherent in the nature of those rights that they are defined and enforceable under state law. *Cf. Daniels v. Williams*, ___ U.S. ___, 106 S.Ct. 662 (1986); *Davidson v. Cannon*, ___U.S. ___, 106 S.Ct. 668 (1986); *Parratt v. Taylor*, 451 U.S. 527 (1981) (state administrative and judicial review procedures may satisfy due process requirements).

Reimbursement review at the state level has the virtue of allowing individual reimbursement decisions to be reviewed in connection with state rates, by state tribunals familiar with the often complex state rate structures and reimbursement procedures. The unique "heavy cost" rule at issue in this case is a good example of the detailed provisions of state Medicaid plans that, under the Ninth Circuit's decision, federal district courts would be called upon routinely to construe.

Even if, as the Ninth Circuit apparently concluded, the federal statute in issue fairly could be read to prescribe a national standard applicable to the acts alleged in plaintiffs' complaint, the standard is so broad as to "simply defy judicial enforcement." *Wright v. City of Roanoke Redevelopment and Housing Authority*, ___ U.S. ___, 107 S.Ct. 766, 778 (1987) (O'Connor, J., dissenting). The Court should be reluctant to recognize an enforceable statutory right where Congress does not enunciate a standard by which the size and shape of that right readily may be measured and defined. "Congress sometimes legislates by innuendo, making declarations of policy and indicating a preference while requiring measures that, though falling short of legislating its goals, serve as a nudge in the preferred directions." *Rosado v. Wyman*, 397 U.S. 397, 413 (1970). When it does so, the Court should not readily interpret Congress' hortatory leanings as a mandate for judicial definition of "rights" toward which the Congress has left only the dimmest trail.

The recognition of a statutory right, and an attendant cause of action under 42 U.S.C. § 1983, can have dramatic consequences with respect to the allocation of responsibility for shaping national policy regarding the subject of the right. Congress here expressed no more than a goal of "reasonable and adequate" reimbursement, 42 U.S.C. § 1396a(a)(13)(A), and "reasonable access" to hospital services of "adequate quality." *Ibid.* Characterization of these broad objectives as rights effectively imputes to Congress an intent to require federal courts to flesh out critical aspects of national health policy. Just as the Court should be cautious in finding federal jurisdiction over claims that do not clearly fit within the terms of a jurisdictional statute, *Chapman v. Houston Welfare Rights Org.*, 441 U.S. at 612, so too should the Court be hesitant to assume responsibility for giving form and

substance to statutory rights. *See Wright v. City of Roanoke Redevelopment and Housing Authority*, 107 S.Ct. at 778 (O'Connor, J., dissenting). Caution particularly is appropriate in this case because plaintiffs' construction of the pertinent statute is fraught with serious constitutional problems under this Court's Eleventh Amendment jurisprudence.

III. The Ninth Circuit's Construction of 42 U.S.C. § 1396a Contradicts Well-Established Eleventh Amendment Precepts.

Caution governed neither the court of appeals' construction of the Medicaid Act, nor its consequent exercise of federal court jurisdiction over plaintiffs' claims. When the Ninth Circuit misconstrued 42 U.S.C. § 1396a as creating rights enforceable against the states in federal court, the court also violated a cardinal rule of statutory construction. If fairly possible, a statute should be construed to avoid serious constitutional problems. *International Machinists v. Street*, 367 U.S. 740, 749-50 (1961). Apparently blinded by its misreading of *Thiboutot*, the Ninth Circuit failed to see the obvious constitutional roadblock to its interpretation of the Medicaid Act: the Eleventh Amendment bars adjudication of plaintiffs' claims in federal court.

Plaintiffs sought, in federal court, retroactive monetary damages and prospective injunctive and declaratory relief against the state, one of its agencies and one of its officials. (J.A. at 7-9). Yet, despite the lack of any claim that the state had consented to be sued in federal court, the Ninth Circuit ignored the principles recently enunciated by this Court in *Pennhurst II* "that in the absence of consent a suit in which the State or one of its agencies or departments is named as the defendant is proscribed by the Eleventh Amendment" and "[t]his jurisdictional bar applies regardless of the nature of the relief sought." 465 U.S. at 100.

The appeals court also bypassed this Court's ruling in *Dept. of Health v. Florida Nursing Home Assn.*, 450 U.S. 147, 149-50 (1981). There, the Court directly held that the mere fact that a state participates in the Medicaid program does not constitute a waiver of Eleventh Amendment immunity. Consequently, Oregon's participation in the Medicaid program itself provides no basis for asserting federal court jurisdiction over the state.

Moreover, 42 U.S.C. § 1396a(a), contains no expression of congressional intent to abrogate the state's Eleventh Amendment immunity from suit in federal court. In fact, Congress expressly repealed an Eleventh Amendment waiver provision, which for a very brief time, was contained in the Medicaid Act.[32] When faced with another statutory scheme (§ 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 749) which similarly contains no expression of congressional intent to abrogate the states' sovereign immunity, this Court stated:

> [I]t is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrules the guarantees of the Eleventh Amendment. The requirement that Congress unequivocally express this intention in the statutory language ensures such certainty.

Atascadero State Hospital v. Scanlon, 473 U.S. at 243. *See also Welch v. Dept. of Texas Highway and Public Transportation*, ___ U.S. ___, 107 S.Ct. ___, 55 U.S.L.W. 5046 (June 25, 1987).

The Ninth Circuit did not even acknowledge these principles, let alone follow this Court's holdings in *Atascadero*, *Welch* and *Florida Nursing Home Assn.* that, in comparable

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[32] Congress, on the last day of the 1975 session, amended the Medicaid Act to require participating states to waive their Eleventh Amendment immunity and consent to be sued in federal court by or on behalf of hospitals with respect to the payment of reasonable costs for hospital services. The Eleventh Amendment waiver/penalty provision raised a firestorm of protest by the states. *See* House Interstate and Foreign Commerce Committee, H. Rep. No. 1122, 94th Cong., 2nd Sess. 4, 5 (1976). Congress promptly repealed the provision the following year. Pub. L. No. 94-552 (1976).

circumstances, the state is immune from federal court suit. The Ninth Circuit evidently refused to be guided by this Court's Eleventh Amendment jurisprudence.

If, in reinstating plaintiffs' complaint, the Ninth Circuit meant only to restore plaintiffs' claims against the defendant state officer, it did not say so in its opinion. Instead, the appeals court opinion silently tolerated a § 1983 claim made against a state and one of its agencies in federal court. This precedent flies directly in the face of the holding in *Edelman v. Jordan*, 415 U.S. 651, 674-77 (1974) (*Edelman*), that § 1983 was not intended to create a waiver of a state's Eleventh Amendment immunity.[33]

With regard to plaintiffs' claims against the defendant state officer, the Ninth Circuit drew no distinction between claims for monetary relief and claims for injunctive relief. Clearly, however, the claim for retroactive monetary damages is barred by the Eleventh Amendment. Although this rule also was firmly established in *Edelman*, 415 U.S. at 666-71, and confirmed in *Pennhurst II*, 465 U.S. at 102-03, the Ninth Circuit paid the rule no heed. Nor did the lower court consider whether the claim for prospective relief is in reality a claim against the state which is barred by the Eleventh Amendment. This is just such a case.

In *Pennhurst II*, 465 U.S. at 101-02, this Court restated a fundamental Eleventh Amendment principle in the following terms:

> [A]s when the state itself is named as the defendant, a suit against state officials that is in fact a suit against the State is barred regardless of whether it seeks

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[33] Through lack of proper analysis, the Ninth Circuit appears to have assumed that the state is a "person" for purposes of 42 U.S.C. § 1983, and thus a proper party defendant in this action, notwithstanding "the threshold fact of congressional authorization to sue a class of defendants which *literally* includes states is wholly absent [from 42 U.S.C. § 1983]." *Edelman v. Jordan*, 415 U.S. 651, 672 (1974) (emphasis in original).

damages or injunctive relief. *See Cory v. White*, 457 U.S. 85, 91 (1982).

The Court in *Pennhurst II* recognized that under the fiction of *Ex parte Young*, 209 U.S. 123 (1908), the Eleventh Amendment does not bar a federal court suit against a state official for prospective injunctive relief from an alleged violation of *federal* law, because a state officer violating *federal* law is thereby stripped of authorization to act for the state. However, the Court observed that "the theory of *Young* has not been provided an expansive interpretation." *Pennhurst II*, 465 U.S. at 102 (citing *Edelman*). In *Pennhurst II*, this Court rejected the contention that federal courts have jurisdiction to entertain a suit for prospective relief against a state official alleged to have violated *state* law:

> In such a case the entire basis for the doctrine of *Young* and *Edelman* disappears. A federal court's grant of relief against state officials on the basis of state law, whether prospective or retroactive, does not vindicate the supreme authority of federal law. On the contrary, *it is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law. Such a result conflicts directly with the principles of federalism that underlie the Eleventh Amendment.* We conclude that *Young* and *Edelman* are inapplicable in a suit against state officials on the basis of state law.

465 U.S. at 106 (emphasis added). That rationale applies in this case.

Here, plaintiffs seek federal judicial enforcement of provisions of the state's Heavy Cost Program. That program is mandated and circumscribed exclusively by state law. No federal statute or regulation requires implementation of a "heavy cost" reimbursement program. Consequently federal court enforcement of the program will not "vindicate" the supremacy of federal law. Stated in *Ex Parte Young* terms,

failure by the state administrator to follow the requirements of state law would not deprive him of his authority to act for the state. The Eleventh Amendment, therefore, bars this action in federal court.

Plaintiffs presumably will assert that, in this case, state law has a federal overlay by virtue of the provisions of the federal Medicaid Act. But particularly in this area of state-federal cooperative funding programs, important values of federalism are at stake. Even if plaintiffs' claim meaningfully could be distinguished from the state law claim in *Pennhurst II*, due respect for the "constitutionally mandated balance of power between the States and the Federal Government," *Garcia*, 469 U.S. at 572 (Powell, J., dissenting), nevertheless requires more from Congress before state Medicaid officials may be hailed into federal court to answer claims challenging the state's cost reimbursement rates.

At a minimum, a state is entitled to prior notification by Congress of its susceptibility to federal court suit through an unequivocally expressed requirement of Eleventh Amendment waiver or an unequivocally expressed statement that Congress intends to abrogate the states' sovereign immunity in the federal Medicaid Act. As discussed above, however, no abrogation language is used in the Medicaid Act, a prior Eleventh Amendment waiver provision was repealed, and this Court already has determined that mere participation by a state in the Medicaid funding program does not constitute a waiver of Eleventh Amendment immunity.

Due consideration of these factors should have counselled the Ninth Circuit to re-examine its construction of the Medicaid Act; due regard for the constitutional significance of these factors compels a different construction of the statute.

CONCLUSION

Plaintiffs' complaint failed to state a cause of action or a basis for federal court jurisdiction. The Ninth Circuit misconstrued Title XIX of the Social Security Act when it

concluded that the plaintiffs were entitled to maintain an action in federal court under 42 U.S.C. § 1983. The Ninth Circuit, therefore, erred in reversing the district court's dismissal of the complaint. This Court should reverse the decision of the Ninth Circuit and remand with instructions to reinstate the judgment for defendants that was entered in district court.

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No. 86-1419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, INC., an Oregon Corporation; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Gibbs; and SANDI WATSON-STOWELL, Guardian Ad Litem for Tami Watson,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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RESPONDENT'S MOTION TO DISMISS

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QUESTIONS PRESENTED

1. Must the writ of certiorari be dismissed for mootness and lack of jurisdiction because, due to the sale of Coos Bay Care Center to an unrelated third party, respondent Coos Bay no longer operates a nursing home or participates in the Oregon Medicaid Program and the only claims still at issue seek retrospective money damages barred by the Eleventh Amendment?

2. Should this Court dismiss the writ of certiorari when, in addition to the jurisdictional defects resulting from the sale of the Coos Bay Care Center, the issues presented for the Court's review were not addressed by the lower courts and the record is inadequate to allow review of the issues presented?

RULE 28.1 LIST

Respondent Coos Bay Care Center, Inc. has no parent company, subsidiaries or corporate affiliates to list pursuant to Rule 28.1.

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RESPONDENT'S MOTION TO DISMISS ON GROUNDS OF MOOTNESS [1]

OPINIONS BELOW

Respondent Coos Bay Care Center, Inc. ("Coos Bay") adopts the statement of Opinions Below contained in the Brief on the Merits for Petitioners (Pet. Brief at 1).

JURISDICTION

Respondent Coos Bay adopts the statement of jurisdiction contained in the Brief on the Merits for Petitioners (Pet. Brief at 1) except to note that a judgment was not entered by the Ninth Circuit Court of Appeals. Rather, the Court of Appeals merely reversed the District Court's order dismissing the Complaint with prejudice and remanded the case to the District Court for consideration of the merits of the case. (*See* Pet. Cert. Brief, App. A.)

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

Respondent Coos Bay adopts the Petitioners' Statement of Statutes and Regulations (Pet. Brief at 1-4) involved for the purposes of this Motion, with the following additions:

1. Article III, Section 2, Clause 1 of the Constitution provides:

> The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or

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[1] This Motion is filed on behalf of respondent Coos Bay Care Center, Inc. As used in this motion, the term "respondents" refers both to Coos Bay Care Center and the individual respondents. Although counsel has entered his appearance only on behalf of Coos Bay Care Center, counsel has been authorized to represent respondent Hannah Schwanke. Appropriate documents to substitute Coos Bay's counsel for Ms. Schwanke's present counsel are awaiting execution by Mr. Lojek.

> which shall be made, under their Authority;—to all Cases affecting Ambassadors, other public Ministers and Consuls;—to all Cases of admiralty and maritime Jurisdiction; to Controversies to which the United States shall be a Party;—to Controversies between two or more States;—between a State and Citizens of another State;—between Citizens of different States, between Citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

U.S. Const. art. III, § 2, cl. 1.

2. The Eleventh Amendment to the United States Constitution provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or Citizens or Subjects of any Foreign State.

U.S. Const. amend. XI.

3. 42 U.S.C. § 1983 provides that:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 U.S.C. § 1983.

STATEMENT OF THE CASE

At the time this suit was filed, respondent Coos Bay Care Center, Inc. operated a nursing home which provided nursing care and related services to aged and developmentally disabled patients. (Pet. Cert. Brief at App-10.) Coos Bay leased the land, buildings, fixtures and most of the equipment utilized in its nursing home from Shoreline Properties, an Oregon partnership. (Joint Affidavit of James C. Griggs and Robert J. Saalfeld included as Appendix A to this Motion at 2a, ¶ 2.) At the time the Complaint was filed, Coos Bay was certified as a provider of services eligible to receive payment for nursing care and services rendered to patients who were beneficiaries of the program established pursuant to the federal Medicaid Act. 42 U.S.C. § 1396 *et seq.*[2] (*See* Pet. Cert. Brief at App-10.)

Respondents filed this suit under 42 U.S.C. § 1983 seeking declaratory and injunctive relief as well as damages. Respondents alleged that the Oregon Medicaid Program calculated and reimbursed Coos Bay Care Center for the cost of care rendered to certain nursing home patients in a manner which violated the federal Medicaid Act, 42 U.S.C. § 1396a(a)(13)(A). (Pet. Cert. Brief at App-37.) The prospective component of the relief sought an order compelling the State to calculate and to pay the nursing home in the manner and at the level required by the federal Medicaid Act. (Pet. Cert. Brief at App-38.) In addition, respondents sought damages for the nursing home in an amount "which represents the lack of appropriate reimbursement from May 26, 1982 to the date of the judgment" and an additional sum for each of the individual respondents. (*Id.*)[3]

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[2] Respondents include the nursing home and two individuals. The individual respondents are the guardians *ad litem* for three of the patients who resided in the nursing home at the time suit was filed. Hannah Schwanke is listed in the Complaint and on the Brief in Opposition to Certiorari as the guardian *ad litem* for David and Steven Schwanke. However, the correct names of Ms. Schwanke's sons are David and Steven Gibbs. In addition, the correct name of the second individual respondent is Sandi Watson-Stowell. The correct name of Ms. Watson-Stowell's ward is Tami Watson, not Tami Mauer as listed in the Complaint. Finally, counsel has been advised by the present operator of the nursing home that Tami Watson has not been a patient at the respondent nursing home for approximately three years.

[3] The case was filed as a class action, but does not appear to have been certified as such by the District Court.

Defendants are the Oregon Department of Human Resources ("DHR"), the "single state agency" designated pursuant to 42 U.S.C. § 1396a(a)(5) to administer the Oregon Medicaid Program (*Id.* at App-32), and Richard C. Ladd, the administrator of the division of DHR directly responsible for the Oregon Medicaid Program. (*Id.*)

Respondent Coos Bay no longer operates a nursing home and is no longer eligible to participate in the Oregon Medicaid Program. On June 30, 1987 Southmark Corporation purchased a group of twenty-seven nursing homes, including the nursing home formerly operated by Coos Bay.[4] (*See* Joint Affidavit of James C. Griggs and Robert J. Saalfeld at 2a, ¶ 3 (hereafter "Joint Affidavit")). Southmark purchased only designated assets of the nursing home's former owners, Shoreline Properties and Coos Bay, not including accounts receivable or claims against government reimbursement programs. (*Id.*) [5]

Southmark assigned the assets which it purchased to Coos Bay Associates Limited Partnership, an entity controlled by Southmark. Neither Southmark nor Coos Bay Associates Limited Partnership are related in any way to Coos Bay Care Center, Shoreline Properties, or any of the partners or shareholders in such entities. (Joint Affidavit at 2a, ¶ 3.)

Coos Bay's Medicaid provider agreement with the State of Oregon—which established the nursing home's right to payment from the Oregon Medicaid Program—automatically terminated on June 30, 1987, the date on which ownership of the nursing home was transferred.[6] (Affidavit of Robert M.

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[4] The Agreement of Sale and Purchase encompassed twenty-eight nursing homes, one of which was rejected by the Southmark Corporation at the closing, pursuant to the terms of that Agreement.

[5] Petitioners were notified of the intent to sell and the actual sale on several occasions. Notice was provided by letters dated March 27, 1987, April 15, 1987 and June 23, 1987. (Decker Affidavit at 11a, ¶¶ 4-5.) In addition, applications were made in the name of the new owner to relicense and to recertify the nursing home to participate in the Medicaid Program on April 17, 1987. (*Id.* at ¶ 6.)

[6] Although Coos Bay, technically speaking, continued to participate in the Medicaid Program until June 30, 1987, the date of the sale to Southmark, practical control and possession of the nursing home was transferred to

(footnote continues)

Decker, included as Appendix B to this Motion at 12a, ¶ 7.) Shoreline Properties and Coos Bay continue to exist and to own assets, including accrued accounts receivable attributable to care and services rendered prior to July 1, 1987. (Joint Affidavit at 2a-3a, ¶ 3.) Southmark Corporation, the new owner of the nursing home, has not joined Coos Bay in this litigation against the State of Oregon for proper Medicaid reimbursement. Coos Bay's only outstanding claims against the Oregon Medicaid Program are for accrued liabilities—payment for services rendered on or before June 30, 1987—the date on which the nursing home was sold to Southmark.[7] The details of the negotiation and sale are set forth in the Joint Affidavit at 1a-9a.

SUMMARY OF THE ARGUMENT

Respondent Coos Bay Care Center, Inc. ("Coos Bay") hereby moves this Court to dismiss the writ of certiorari granted in this case and to remand this case to the United States Court of Appeals for the Ninth Circuit with directions to dismiss for lack of jurisdiction. Events occurring after this Court granted the petition for writ of certiorari—namely, the sale of substan-

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(footnote continued)

Southmark by a Management Agreement on April 1, 1987. The Management Agreement provided that Southmark was "solely and exclusively entitled to receive all revenue and pay all expenses" of the nursing homes covered by the Agreement, including Coos Bay, effective April 1, 1987. (Joint Affidavit at 4a, ¶ 9.)

[7] The April 1, 1987 Agreement of Sale and Purchase, which governed the sale of the nursing home operations to Southmark Corporation, provides that patient charges (*i.e.*, rents) and other sums payable by or on behalf of the patients are not to be prorated at the sale's closing. (Joint Affidavit at 7a, ¶ 14.) The Agreement also provides that all payments received from governmental reimbursement programs shall first be applied to reduce the accrued liabilities due the seller (respondent Coos Bay) for each patient covered by the payment. Only the balance, if any, is to be paid to Southmark, the purchaser. The Agreement specifically permits the seller to pursue legal relief for delinquent claims for accrued liabilities. (*See id.*) The parties to the sale and purchase discussed the claim against the Oregon Medicaid Program and agreed that the claim was not among the assets purchased by Southmark. (*See* Affidavit of Don R. Bybee, included as Appendix C to this Motion at 15a, ¶ 3.)

tially all of the assets of the respondent nursing home—render moot respondents' claims for prospective declaratory and injunctive relief. The Eleventh Amendment bars respondents' remaining claims for retrospective relief. There is no doubt that there is no remaining case or controversy which can be adjudicated in a federal court. Therefore, the case must be dismissed.

ARGUMENT

I. THIS CASE MUST BE DISMISSED BECAUSE THE FEDERAL COURTS DO NOT HAVE JURISDICTION TO HEAR RESPONDENTS' CLAIMS, OR TO AWARD RELIEF.

Jurisdiction over respondents' case is barred for two reasons. First, the sale of the nursing home rendered respondents' claims for prospective relief moot.[8] Second, the Eleventh Amendment precludes federal jurisdiction over the only claims remaining in this action, those for increased Medicaid payment for services rendered prior to the date the nursing home was sold. The writ of certiorari ought to be dismissed.

Article III of the Constitution requires, as a prerequisite to the exercise of federal jurisdiction, that there exist "a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of [relief]." *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 312

[8] The Complaint predicates the claims of the individual respondents on their status as third party beneficiaries of the now-terminated provider contract. In addition the relief sought by the individual respondents, damages and injunctive relief, was predicated on the same theory advanced by Coos Bay—that the Medicaid Program underpaid the nursing home for their care. In order to prevail therefore, the individual respondents would have to make the same showing as Coos Bay with regard to inadequate reimbursement. However, Coos Bay no longer provides services to the individual respondents. The new owner of the nursing home has not joined this litigation. There are no allegations that the new owner is under-reimbursed or that the individual respondents are not receiving all appropriate and necessary care from the new owner. The costs incurred by the new owner to serve its patients are likely to be very different than those incurred by Coos Bay, but the record does not address the question. Thus, the individual respondents have alleged no ongoing present violation distinct from the allegations made by Coos Bay. For these reasons, this Motion draws no distinction among the respondents.

U.S. 270, 273 (1941). At all stages of federal court litigation the plaintiffs must be under threat of further injury as a result of defendant's conduct, *cf. Edgar v. MITE Corp.*, 457 U.S. 624 (1982), and have a "personal stake in the outcome" which assures the concrete adverseness necessary for resolution of the issues. *O'Shea v. Littleton*, 414 U.S. 488 (1974); *Baker v. Carr*, 369 U.S. 186, 204 (1962). Thus, a case may become moot and the jurisdiction of the federal courts extinguished, even after certiorari has been granted, if the factual circumstances change so that plaintiff no longer suffers injury which can be remedied by federal court intervention, *see, e.g., Board of License Comm'rs of the Town of Tiverton v. Pastore*, 469 U.S. 238 (1985), or because the statute or regulation at issue in the litigation is amended or modified and the defendant comes into compliance with the law. *See, e.g., Green v. Mansour*, 474 U.S. 64 (1985).

Even where an actual controversy is present, the jurisdiction conferred on the federal courts by Article III of the Constitution is restricted by the Eleventh Amendment.[9] *See, e.g., Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 238 (1985); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 98 (1984). This Court repeatedly has reaffirmed the longstanding rule that the Eleventh Amendment bars federal jurisdiction over a suit against a state by private parties seeking to impose liability which must be paid from public funds in the state treasury. *Edelman v. Jordan*, 415 U.S. 651, 653 (1974).

In *Ex parte Young*, 209 U.S. 123, 128 (1908), however, this Court held that the federal courts retained jurisdiction, notwithstanding the Eleventh Amendment, to order state officials to conform their future conduct to the requirements of

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[9] The Eleventh Amendment to the United States Constitution states:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or Citizens or Subjects of any Foreign State.

Although the language of the Amendment expressly includes only suits against a state by citizens of another state, this Court has held that the Eleventh Amendment bars suits against a State by its own citizens as well. *See, e.g., Hans v. Louisiana*, 134 U.S. 1, 10 (1890); *Papasan v. Allain*, ____ U.S. ____, 106 S. Ct. 2932, 2939 (1986).

federal law, even though injunctive relief might have an ancillary effect on the State treasury. *See also Quern v. Jordan,* 440 U.S. 332, 337 (1979); *Edelman,* 415 U.S. at 667-68. As this Court explained in *Quern v. Jordan,* " [t]he distinction between that relief permissible under the doctrine of *Ex parte Young* and that found barred in *Edelman* was the difference between prospective relief on one hand and retrospective relief on the other." *Quern,* 440 U.S. at 337 (footnote omitted).

This Court has noted that the difference between permissible relief and that which is barred by the Eleventh Amendment "will not in many instances be that between day and night." *Edelman,* 415 U.S. at 667. There are, however, certain types of relief which the decisions of this Court demonstrate clearly are prohibited by the Eleventh Amendment.[10]

Thus, the Eleventh Amendment bars a federal court from awarding "damages," *Kentucky v. Graham,* 473 U.S. 159, 170 (1985), "retroactive" payments, *Pennhurst,* 465 U.S. at 103; *Quern,* 440 U.S. at 333, 338; *Milliken v. Bradley,* 433 U.S. 267, 290 (1977), or "compensation." Indeed, the decisions of this Court establish that the Eleventh Amendment prohibits any retrospective relief against a state which is "measured in terms of a monetary loss resulting from a past breach of a legal duty" by the state or its agents. *Edelman,* 415 U.S. at 668; *Papasan v. Allain,* ____ U.S. ____, 106 S. Ct. 2932, 2940 (1986); *Green,* 106 S. Ct. at 426; *Quern,* 440 U.S. at 337. Federal jurisdiction over a claim against a state is proscribed by the Eleventh Amendment decisions of this Court unless the state is engaged in an "ongoing" "present," or "continuing" violation of the plaintiffs' rights, as opposed to a violation which occurred in the past. *Papasan,* ____ U.S. ___, 106 S. Ct. at 2942; *Green v. Mansour,* 474 U.S. 64, 106 S. Ct. at 426. Further, this Court has long emphasized that the Eleventh Amendment bars federal jurisdiction "to the extent [that] the suit [seeks] 'the award of an *accrued* monetary liability . . .' which represent[s] retroactive payments." *Milliken,* 433 U.S. at 289 and n. 22

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[10] The parties are seemingly in agreement that the Eleventh Amendment bars respondents' claims for retroactive monetary relief. (*See* Pet. Brief at 41 ("Clearly, however, the claim for retroactive monetary damages is barred by the Eleventh Amendment.")).

(*quoting Edelman v. Jordan,* 415 U.S. 651, 664 (1974) (emphasis in original)); *see also Papasan v. Allain,* ___ U.S. ___, 106 S. Ct. 2932, 2942 (1986).

A. The Sale Of The Nursing Home Mooted Respondents' Claims For Prospective Relief.

The sale to Southmark of the nursing home formerly operated by Coos Bay rendered moot respondents' claims for prospective declaratory and injunctive relief. The provider contract between Coos Bay and the Oregon Medicaid Program which authorized Coos Bay to provide covered services to Medicaid beneficiaries and established the nursing home's right to Medicaid reimbursement was terminated by the sale. (*See* Affidavit of Robert M. Decker at 12a, ¶ 7.) Application has been made to have the nursing home relicensed and for a new provider agreement in the name of the new operator. (*Id.*)

Coos Bay is not licensed as a nursing home, no longer has the capacity to deliver nursing care, is not party to a Medicaid provider contract, and cannot seek or be paid Medicaid reimbursement by the Oregon Medicaid Program. The Complaint, however, seeks to compel the State to increase Medicaid payments to Coos Bay to a level sufficient to satisfy the dictates of the Medicaid Act. Because Coos Bay does not have an ongoing relationship with the Oregon Medicaid Program, respondents no longer suffer ongoing injury from the State's conduct and have no claim which can be remedied by prospective relief.

In other, similar situations this Court has dismissed a writ of certiorari after being informed by counsel that the subject of the controversy had sold its business. *Board of License Comm'rs of the Town of Tiverton v. Pastore,* 469 U.S. 238 (1985) (*per curiam*). In *Tiverton,* a case involving whether the exclusionary rule applies in civil liquor license revocation hearings, this Court held that the case became moot because of the sale of the tavern whose license had been revoked. This Court stated that the case was moot because "no decision on the merits by this Court can now have an effect on the [tavern's] liquor license." *Id.,* 469 U.S. at 239. This Court implicitly found that the sale of the business had the "effect of depriving

the Court of jurisdiction due to the absence of a continuing case or controversy. . . ." *Id.*, 469 U.S. at 240. Respondents' effort to compel defendants to conform to the Medicaid Act in the future plainly likewise has been rendered moot by the sale of the nursing home. *See, e.g., Green v. Mansour,* 474 U.S. 64, 106 S. Ct. 423, 424-25 (1985); *Friendship Villa-Clinton v. Buck,* 512 F. Supp. 720 (D. Md. 1981); *cf. Tiverton,* 469 U.S. 238.

B. The Eleventh Amendment Bars Respondents' Remaining Claims For Relief.

The only remaining actual controversy between the parties is whether the Oregon Medicaid Program paid Coos Bay at a rate sufficient to satisfy the federal Medicaid Act for services delivered on and before June 30, 1987, the date of the sale to Southmark. Respondent suffers no ongoing or current injury attributable to the State's illegal conduct. The sole effect of any relief awarded in this case would be to determine that the Oregon Medicaid program had under-reimbursed Coos Bay for nursing care and services rendered prior to the date of the sale to Southmark.

In similar circumstances, this Court repeatedly has held that the Eleventh Amendment deprives federal courts of jurisdiction over claims against a state when the only effect of an order would be to determine the existence or amount of an accrued liability. *See, e.g., Papasan v. Allain,* ____ U.S. ____, 106 S. Ct. 2932, 2942 (1986); *Green v. Mansour,* 474 U.S. 64, 106 S. Ct. 423, 428 (1985). The writ of certiorari ought to be dismissed because any relief awarded to respondents at this stage plainly would be compensatory, retrospective monetary damages measured in terms of the monetary loss which resulted from the State's past breach of the duties imposed by the Medicaid Act—precisely the type of relief proscribed by the Eleventh Amendment.[11]

In fact, on at least four occasions, this Court and the lower federal courts have held that the Eleventh Amendment deprives federal courts of jurisdiction over claims arising under the Social Security Act where, as here, events subsequent to the

[11] The Complaint expressly measures the amount of damages by the amount of under-reimbursement. *See* Pet. Cert. Brief at App-38.

filing of the complaint transform a litigant's claim from one for prospective relief into one which seeks only retrospective money damages. In all four cases, the courts have held that the Eleventh Amendment barred jurisdiction because, as a result of changed circumstances, the plaintiff lost its claim for prospective relief under the challenged provisions of the state-administered program.

In *Green v. Mansour,* 474 U.S. 64, 106 S. Ct. 423 (1985), plaintiffs challenged the state's calculation of benefits paid pursuant to Title IV of the Social Security Act, commonly known as Aid to Families with Dependent Children ("AFDC"). Congress amended the statute before a final decision was rendered on the merits of the claim. There was no dispute that the state was calculating benefit payments as required by the amended statute. Plaintiffs conceded that their claim for *Young* type injunctive relief was rendered moot by the amendments to the AFDC program. Because there was, as here, no present violation of law which continued to injure plaintiffs, this Court held that any relief would be tantamount to an award of damages prohibited by the Eleventh Amendment.

In *Florida Department of Health and Rehabilitative Services v. Florida Nursing Home Association,* 450 U.S. 147 (1981) (*per curiam*), this Court held that the Eleventh Amendment deprived the federal courts of jurisdiction to determine whether certain nursing home reimbursement provisions of the Florida Medicaid Program violated the then-current federal Medicaid Act. After commencement of the litigation, Congress amended the reimbursement provisions of the federal Medicaid Act and adopted a new reimbursement standard. Similarly, Florida abandoned its flat rate payment system and adopted a new payment methodology. Because the plaintiffs' attack on the defunct flat rate payment system was the only cause of action articulated by the nursing home plaintiffs, the only relief available from the federal court, as here, was a determination that the state's past reimbursement practices violated the Medicaid Act. This Court held that Florida had not waived its Eleventh Amendment immunity by participating in the federal Medicaid Program and ordered that the case be dismissed. *Id.,* 450 U.S. at 150.

In *Shashoua v. Quern*, 612 F.2d 282 (7th Cir. 1980) (*per curiam*), the Seventh Circuit reached a similar conclusion. A physician who, at the time suit was filed, had been eligible to be reimbursed for services provided to Medicaid beneficiaries challenged reimbursement provisions of the Illinois Medicaid Program. After the suit was instituted, the physician ceased to have a medical practice which served Medicaid recipients. In addition, the reimbursement schedules, about which the physician originally complained, had been replaced by new regulations. The Court of Appeals held that the claim for prospective relief became moot when the physician stopped providing services covered by the Medicaid Program. As here, there was no present controversy or continuing injury for which prospective relief could be awarded. The case was dismissed because the Eleventh Amendment precluded jurisdiction over the physician's remaining retrospective reimbursement claim against the state.

Friendship Villa—Clinton, Inc. v. Buck, 512 F. Supp. 720 (D. Md. 1981), is practically identical to the present case. Plaintiff Clinton was a licensed nursing home which, like Coos Bay, participated in the Medicaid Program pursuant to a provider contract with the state. In July, 1980, Clinton filed suit seeking declaratory and injunctive relief enjoining the state from calculating Clinton's reimbursable costs in violation of the Medicaid statute and applicable federal regulations. On September 19, 1980, Clinton's parent corporation, Friendship Villa Equity Corporation, sold all of its interests in sixteen nursing homes, including Clinton. Because it no longer operated a nursing home or participated in the Medicaid Program, Clinton, like respondent Coos Bay, lost its claim for prospective relief, retaining only a cause of action for liabilities which had accrued prior to sale of the nursing home, when services were rendered to Medicaid beneficiaries.

The district court held that Clinton's claim for prospective relief became moot when the nursing home ceased to provide services for which payment was available from the Maryland Medicaid Program. The court also held that jurisdiction over claims for increased reimbursement for services provided prior

to the sale was precluded by the Eleventh Amendment. According to the court: "[T]he Eleventh Amendment forbids federal court determination of liability on the part of a state for past benefits owed by a state even when the state provides a method by which claims for such payments may be raised in future state proceedings." *Friendship Villa,* 512 F. Supp. at 725 (D. Md. 1981) (*citing Jordan v. Trainor,* 563 F.2d 873 (7th Cir. 1977), *aff'd sub nom. Quern v. Jordan,* 440 U.S. 332 (1979)).

Green, Florida Nursing Home Association, Shashoua, Friendship Villa and *Tiverton* dictate that this case should be dismissed for lack of jurisdiction. When Coos Bay ceased to operate a nursing home and to participate in the Oregon Medicaid Program, the nursing home's claim for prospective relief became moot. The only effect of any relief which the District Court might award would be to require the Oregon Medicaid Program to provide additional reimbursement for services rendered prior to the sale of the nursing home. Because the respondent patients and their guardians also seek an order increasing Medicaid payments to Coos Bay and because such claims are wholly derivative of Coos Bay's rights under its now-terminated provider contract, the patients' claims also are entirely retrospective.

If this case is not dismissed, respondents will be in the awkward position of prosecuting a claim over which the District Court has no jurisdiction and for which they can obtain no relief in the federal courts. Because the Eleventh Amendment bars federal jurisdiction, respondents' remedy for inadequate Medicaid reimbursement for services rendered prior to the sale of the nursing home lies in a state forum. Further review by this Court is not constitutionally permissible and the case should be dismissed forthwith.

II. THIS COURT SHOULD DISMISS THIS CASE BECAUSE THE ISSUES PRESENTED FOR SUPREME COURT REVIEW WERE NOT ADDRESSED BY THE COURTS BELOW AND BECAUSE THE RECORD IS INADEQUATE FOR SUPREME COURT REVIEW.

Although federal court jurisdiction over this case is barred because of mootness and by the Eleventh Amendment, Supreme Court review in this instance is also inadvisable in light

of the limited record before the Court. It is clear that (1) the issues which certiorari was granted to review were not decided by the lower courts, and (2) the record is not sufficiently developed to permit decision on either issue presented by the petition for writ of certiorari. This Court has stated that a writ of certiorari will be dismissed when plenary consideration "shed[s] more light on [a] case than in the nature of things was afforded at the time the petition for certiorari was considered. . ." *Belcher v. Stengel,* 429 U.S. 118, 119-120 (1976) (*per curiam*).

A. Neither The Ninth Circuit Nor The District Court Decided The Issue of Whether Exhaustion Of Administrative Remedies Was Required Prior To Federal Judicial Review Or Whether There Were Any State Administrative Remedies That Could Have Been Exhausted.

The first issue presented by the petition for writ of certiorari is:

> May health care providers and their patients bypass state remedies and sue under 42 U.S.C. § 1983 to challenge state Medicaid reimbursement decisions when, pursuant to express directives of the Medicaid Act and federal implementing regulations, the state has established administrative procedures specifically to address those claims?

(Pet. Cert. Brief at i.) There are two problems with Supreme Court review of this issue.

Neither the Court of Appeals nor the District Court determined whether there are any state administrative procedures that could have been exhausted. Determination of whether the state has administrative procedures which could have considered respondents' claims and afforded relief is an obvious prerequisite to the question of whether or not respondents must exhaust administrative remedies before they can bring suit under Section 1983. Plainly, respondents could not be directed to pursue state administrative remedies prior to federal judicial review if no such remedies exist.

The Ninth Circuit held that the availability of state administrative remedies was irrelevant. (Pet. Cert. Brief at App-4, n.2.) Since the Court declined "to review the state administrative procedures and contractual remedies assertedly available to plaintiffs under Oregon law", (*id.*), it never determined whether there were in fact any state remedies available which plaintiff might or should have exhausted.[12] Similarly, the District Court expressly refused to determine whether exhaustion of administrative remedies was a precondition to federal judicial review. (*See id.* at App-13.)

In *Smith v. Butler,* 366 U.S. 161 (1961) (*per curiam*), this Court determined that certiorari was improvidently granted when "it became manifest that the course of litigation and the decisions in the [lower] courts did not turn on the issue on the basis of which certiorari was granted." *See also California v. Taylor,* 353 U.S. 553 (1957); *Lawn v. United States,* 355 U.S. 339 (1958); *but see, e.g., Capital Cites Cable, Inc. v. Crisp,* 467 U.S. 691, 697-698 (1984) (*per curiam*) (citations omitted). So it is in this case. Neither the Ninth Circuit's nor the District Court's decisions turned on the issue of whether state remedies were available and those courts therefore never addressed the question whether exhaustion of administrative remedies was a prerequisite to federal court review. Because the lower courts did not determine whether there are, in fact, any state administrative procedures through which plaintiffs might have obtained relief, respondent submits that the Court should not decide this issue.

Further, the uncontradicted evidence in the record is that state Medicaid officials had made clear, prior to filing of this action, that no administrative review was available and that any attempt to pursue the present claims administratively would be futile. As respondents' affidavit of Robert Decker, states:

> Your affiant has been told by these Oregon State officials that it would be futile to pursue any type of

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[12] Not only did the Ninth Circuit not determine if Oregon had in fact established administrative procedures, but it also intimated that the remedies established by the state in response to the federal Medicaid regulations (requiring states to establish administrative review procedures) might not be comprehensive enough. (Pet. Cert. Brief at App-3.)

> administrative procedure or administrative remedy and that, in fact, no administrative procedures were available to your affiant or to his patients which could address this type of problem. Your affiant has further been told that no request for additional funding will be made by the State of Oregon for heavy care patients. . .

(Affidavit of Robert Decker, J.A. at 18.) [13]

In contrast, petitioners claimed that the State of Oregon established administrative procedures and judicial review by statute and administrative rule, and that providers and residents may challenge agency decisions regarding Medicaid reimbursement or benefits. (*See* State of Oregon's Ninth Circuit Brief at 24.) Respondents answered—with support in Mr. Decker's affidavit—that no administrative review was available and that any attempt to exhaust administrative remedies would be futile. The availability and effectiveness of state administrative remedies was disputed as a matter of fact and law, but the conflict never was resolved by the courts below.

At best, the record before the Court demonstrates that there were no available or effective state administrative procedures through which respondents might have obtained relief. In such case there is no basis for Supreme Court review, for respondents cannot be remanded to non-existent or futile administrative procedures. *See United States v. Anthony Grace & Sons, Inc.*, 384 U.S. 424, 429-430 (1966). At worst, the record is unclear as to the availability and effectiveness of state administrative remedies. The failure of the courts below to determine whether state administrative remedies existed and should have been exhausted before federal judicial review obscures the question presented for review by this Court and requires this Court to resolve, in the first instance, issues of state law more appropriately left to the lower courts in the first instance.

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[13] Nowhere in any of the proceedings below did Petitioners by way of affidavit, argument or otherwise, even attempt to refute Mr. Decker's statement.

In *Kimbrough v. United States,* 364 U.S. 661 (1961) (*per curiam*), this Court dismissed a writ of certiorari after concluding, upon a more thorough review of the record than was possible when the petition for certiorari was granted, that the statutory questions were "not presented with sufficient clarity. . ." *See also Massachusetts v. Painten,* 389 U.S. 560, 561 (1968) (This Court dismissed a writ of certiorari as improvidently granted when it found that the record was not "sufficiently clear and specific to permit decision of the important constitutional questions involved" in the case).

Before this Court holds that the respondents should have exhausted state administrative remedies it must be determined that such remedies exist and that the effort to present the claims would not have been futile as alleged by respondents. The need for this Court to dispositively determine mixed questions of state law and of fact in the first instance on a limited record suggests strongly, in conjunction with the mootness and Eleventh Amendment problems already discussed, that this case should be dismissed.[14]

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[14] Even if the exhaustion question were properly presented, Supreme Court review of this issue would be unwarranted. This Court already has considered whether exhaustion of administrative remedies is a predicate to federal judicial review of claims against state agencies participating in joint federal-state programs created by the Social Security Act. In *King v. Smith,* 392 U.S. 309 (1968), for example, this Court, despite a statutory requirement that states create a fair hearing process, held that claimants to Aid to Families for Dependent Children benefits under Title IV of the Social Security Act did not have to exhaust state administrative remedies prior to seeking federal judicial review. *Id.,* 392 U.S. at 312 n.4. Similarly, in *Rosado v. Wyman,* 397 U.S. 397, 406 (1970) this Court held that exhaustion of federal administrative remedies was not a prerequisite to federal judicial review of claims that a state was violating the Social Security Act. *See also Wright v. Roanoke Redevelopment Housing Authority,* _____U.S._____, 107 S. Ct. 766, 773 (1987).

King and *Rosado* have been cornerstones of Social Security Act jurisprudence for almost twenty years. If the Court wishes to reconsider *King* and *Rosado,* it should do so based on a fully developed record which presents the issues in a concrete fashion. The District Court and the Courts of Appeals are in the best position to resolve the mixed questions of fact and state law presented by the record here. Moreover, this Court ought to have the benefit of the views of the lower courts on the issue before conducting its own review.

B. Neither The Ninth Circuit Nor The District Court Ruled That A Violation Of The State Medicaid Plan Constituted A Violation Of Federal Law, *i.e.*, The Medicaid Act, Actionable Under Section 1983, Nor Is There A Conflict In The Lower Courts On This Question.

The second issue presented by the petition for writ of certiorari is:

> Do the rate reimbursement provisions established by the states as a part of their state Medicaid Plans give rise to federal rights enforceable under 42 U.S.C. §1983?

(Pet. Cert. Brief at i.) Review of this issue is unwarranted for several reasons in addition to the jurisdictional defects noted previously.

The Court of Appeals and the District Court did not decide whether violation of a State Medicaid Plan was the equivalent of violation of the Medicaid Act and therefore actionable under Section 1983. In fact, the Court of Appeals, in its opinion, never even alludes to the existence of the State Medicaid Plan. The court held that plaintiffs had alleged a direct violation of the reimbursement provisions of the federal Medicaid Act. The court specifically stated:

> To prevail on the merits, plaintiffs must convince the trial court that the actions and non-action of the State of Oregon violate the standard set out in 42 U.S.C. § 1396a(a)(13)(A).

(*See* Pet. Cert. Brief at App-5.) The Court of Appeals held that such an alleged violation of the Social Security Act stated a cause of action under this Court's decision in *Maine v. Thiboutot*, 448 U.S. 1 (1980).

Once again, the rule of *Smith v. Butler*, 366 U.S. 161 (1961) (per curiam), that the Court should not review questions not decided below, suggests that the writ of certiorari should be dismissed as improvidently granted. The alleged

violation of the State Medicaid Plan played absolutely no role whatsoever in the decisions of the courts below.

Even if the Court of Appeals had decided that violation of a State Medicaid Plan, *ipso facto,* constitutes a violation of federal law, *i.e.,* the Medicaid Act, actionable under Section 1983, Supreme Court review is unwarranted. Courts have consistently held that violation of similar state plans constitutes a violation of federal law subject to federal judicial review. *See Barnes v. Cohen,* 749 F.2d 1009 (3d Cir. 1984), *cert. denied,* 471 U.S. 1061 (1985); *Rose v. Heintz,* 806 F 2d 389 (2d Cir. 1986); *Geis v. Board of Education,* 774 F.2d 575 (3d Cir. 1985); *Everett v. Schramm,* 772 F.2d 1114 (3d Cir. 1985); *David D. v. Dartmouth School Committee,* 775 F.2d 411 (1st Cir. 1985), *cert. denied, sub nom. Massachusetts Dep't of Education v. David D.,* ____ U.S. ____, 106 S. Ct. 1790 (1986); *Miami University Associated Student Government v. Schriver,* 735 F.2d 201 (6th Cir. 1984); *Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services,* 634 F. Supp. 1313 (E.D. Wis. 1986) (vacated pursuant to a stipulated settlement order). The consistency in the decisions of the Courts of Appeals strongly suggests that Supreme Court review of this issue is not necessary. *See Layne & Bowler Corp. v. Western Well Works, Inc.,* 261 U.S. 387 (1923).

CONCLUSION

In this case, there is no longer an ongoing "case or controversy" between the parties. Therefore, with respect to respondents' claims for prospective relief, the case has become moot. Respondents' only remaining claims against the Oregon Medicaid Program are for increased reimbursement for accrued liabilities incurred for services rendered prior to sale of the nursing home on June 30, 1987. Respondent Coos Bay submits that the writ of certiorari would not have been granted if this case had been in its present posture when the writ was sought.

The inappropriateness of Supreme Court review in this case is further exacerbated by the fact that the lower courts did not decide the issues raised in the petition for certiorari and by the absence of a fully developed record. Respondent Coos Bay therefore respectfully requests that this Court dismiss the writ of certiorari and remand the case to the United States Court of Appeals for the Ninth Circuit with directions to dismiss for lack of jurisdiction. *See United States v. Munsingwear, Inc.*, 340 U.S. 36, 39-41 (1950).

Respectfully submitted,

*MALCOLM J. HARKINS, III
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CASSON, CALLIGARO & MUTRYN
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Counsel for Respondent,
Coos Bay Care Center, Inc.

* *Counsel of Record*

Appendix A

(EXHIBITS TO AFFIDAVITS OMITTED IN PRINTING)
(SIGNATURES AND HANDWRITTEN MATERIAL OMITTED IN PRINTING)

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1419

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon corporation; Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

JOINT AFFIDAVIT OF JAMES C. GRIGGS AND ROBERT J. SAALFELD

James C. Griggs and Robert J. Saalfeld being duly sworn according to law jointly depose and state as follows:

1. James C. Griggs is an attorney licensed to practice law in the State of Oregon since December 23, 1975. Robert J. Saalfeld is an attorney licensed to practice law in the State of Oregon since November 7, 1974. Mr. Saalfeld is a member of the bar of this Court and has appeared on the brief in opposition to the petition for writ of certiorari in this case. Messrs. Griggs and Saalfeld are members of

the law firm of Harland, Ritter, Saalfeld, Griggs & Gorsuch, P.C., 693 Chemeketa Street N.E., Salem, Oregon 97301.

2. Messrs. Griggs and Saalfeld have represented respondent Coos Bay Center Center, Inc. ("CBBC, Inc.") for four (4) years and its president, Don R. Bybee for seven (7) years. Prior to July 1, 1987, CBCC, Inc. operated the nursing home which seeks additional Medicaid reimbursement in the present action. However, prior to July 1, 1987 the land, building, fixtures and most of the equipment utilized by CBCC, Inc. to provide nursing home services were owned by Shoreline Properties, an Oregon partnership, and leased to CBCC, Inc.. Mr. Bybee owns a fifty percent interest in Shoreline Properties. Messrs. Griggs and Saalfeld have represented Shoreline Properties for three (3) years. The nature of legal services performed on behalf of CBCC, Inc., Shoreline Properties and Mr. Bybee by Messrs. Griggs and Saalfeld have been to advise CBCC, Inc., its president and Shoreline with respect to tax, real estate, corporate and related matters.

3. Messrs. Griggs and Saalfeld jointly negotiated and closed the sale of a group of twenty-eight nursing homes, including the nursing home operated by CBCC, Inc. to Southmark Corporation and its assignees. Southmark Corporation was not and is not related to CBCC, Inc., Shoreline Properties, Mr. Bybee or to any other person or entity which formerly held an ownership or operating interest in CBCC, Inc. or in Shoreline Properties. The sale of the assets of Shoreline Properties and CBCC, Inc. principally the land, buildings, fixtures, equipment and operations of the nursing home formerly operated by CBCC, Inc. closed on June 30, 1987. Southmark purchased only the designated assets of Shoreline Properties and CBCC, Inc., not including accounts receivable or claims against governmental reimbursement programs. Shoreline Properties and CBCC, Inc. continue to exist and own assets, including accrued accounts receivable attribut-

able to care and services rendered prior to July 1, 1987. Effective upon the date of the change of ownership, however, CBCC, Inc. ceased to provide services to beneficiaries of the Medicaid Program, and its only outstanding claims against the Oregon Medicaid Program are for payment for services rendered on or before June 30, 1987, the date of closing. The background of the sale and purchase transaction is set forth below.

4. Prior to July 1, 1987, CBCC, Inc. was a party to a "provider agreement" with the State of Oregon. Pursuant to the provider agreement, the State of Oregon agreed to pay CBCC, Inc. for nursing care and related services rendered to beneficiaries of the joint federal-state program established pursuant to the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* Payment to CBCC, Inc. was to be made at the rates determined using the payment methodologies set forth in the Medicaid Act and in the Oregon State Medicaid Plan. In the dispute presently before this Court, CBCC, Inc. and several of its patients allege that the Oregon State Medicaid Plan and the payment methodologies set forth in such plan were adopted in violation of the Medicaid Act and its implementing regulations.

5. In November, 1986, Southmark entered into negotiations with Mr. Bybee to lease a group of nursing homes, including CBCC, Inc. In February, 1987, Southmark submitted to Mr. Bybee a formal, written proposal to lease certain designated nursing homes, including CBCC, Inc. After further discussions, however, Mr. Bybee agreed to consider selling the nursing homes to Southmark if acceptable terms could be agreed upon.

6. On February 18, 1987, the parties entered into a formal letter of intent to sell and to purchase a group of forty-one specified nursing homes, including the nursing home which was then operated by CBCC, Inc. The letter of intent was binding on both parties, subject to certain rights reserved to Southmark, such as the right to inspect the nursing home operated by CBCC, Inc. and certain

other designated nursing homes in the group. The letter of intent established a closing date of April 3, 1987 for the sale of all of the nursing homes.

7. In mid-March, 1987, the transaction stalled due to certain difficulties encountered in connection with the purchase of thirteen of the nursing homes included in the original group of forty-one identified in the February 18, 1987 letter of intent. After further negotiations, the parties agreed to continue with the sale and purchase, but to delete from the transaction the thirteen nursing homes which had become problematic.

8. Because of the difficulties encountered in resolving the issues created by the thirteen problematic nursing homes and as a result of further negotiations between the parties, it was not possible to close the sale and purchase of the remaining twenty-eight nursing homes on April 3, 1987 as agreed in the letter of intent. The parties therefore agreed to enter a Management Agreement and executed an Agreement of Sale and Purchase on April 1, 1987. The Management Agreement and the Agreement of Sale and Purchase covered each of the remaining twenty-eight nursing homes, including the nursing home operated by CBCC, Inc. The parties established a new, tentative closing date of June 1, 1987.

9. The effect of the Management Agreement was to transfer possession and operational control of the nursing homes, including CBCC, Inc., to the buyer, Southmark Corporation, effective April 1, 1987. For example, the Management Agreement provides that "during the term of this Agreement, the Manager [i.e., Southmark] . . . shall be solely and exclusively entitled to receive all revenue and pay all expenses and shall be fully responsible for the management of the Facility and all operations thereof." *See* Exhibit No. A, ¶ 2. Southmark managed the nursing homes, including the nursing home operated by CBCC, Inc. through its subsidiary National Heritage Management, Inc. ("NHI").

10. The Agreement of Purchase and Sale also was dated April 1, 1987. The Agreement provided for the sale and purchase of twenty-eight nursing homes, including the nursing home operated by CBCC, Ind. The Agreement specifically afforded the buyer, i.e., Southmark, "the remedy of specific performance of the obligations of Seller under this Agreement." *See* Exhibit B, § VIII, ¶ B at 28. The Agreement also recognized that "Coos Bay Care Center . . . is the subject of a dispute between Bybee and Gabrielson who are entering into this Agreement, and certain other partners of that Seller who are not parties to this Agreement." *See* Exhibit B, § V, ¶ G at 25. The dispute referred to in the Agreement related to the refusal of all partners in Shoreline Properties, the owner of the land, building and equipment utilized by CBCC, Inc. in its nursing home operations, to consent to the sale. Consent of all partners was a prerequisite to the sale. The Agreement obligated Mr. Bybee to "bring an action or proceeding. . . to require the Seller of Coos Bay to convey Coos Bay to Purchaser." *Id.* The obligation was imposed on Mr. Bybee to pursue legal action to require conveyance of the nursing home and related assets because the parties were not certain all of the Shoreline Properties partners would provide the required consent for the sale.

11. Sale and purchase of the nursing home operated by CBCC, Inc. required conveyance by both Shoreline Properties, the owner of the land, building fixtures and equipment and by CBCC, Inc., the lessee-operator of the nursing home. Southmark had made clear throughout the negotiations that it would purchase only the assets of the nursing homes and only if they could be obtained in fee simple. Southmark had no interest in purchasing and would refuse to purchase the operations of any nursing home without the land, buildings, equipment and related assets. Refusal of any of the Shoreline partners to consent to the sale would have stopped the sale of the land, buildings, fixtures and equipment utilized by CBCC, Inc. to operate the nursing home. If the assets owned by Shore-

line Properties could not be conveyed, the sale and purchase of the nursing home operated by CBCC, Inc. would not have been consummated.

12. At this time the parties contemplated closing the sale, assuming that all preconditions were satisfied, on May 30, 1987. However, in late April, 1987, the parties determined that the transaction was subject to pre-notification requirements imposed by the Hart-Scott-Rodino Act, 15 U.S.C. § 18a. The seller made the required filing with the Federal Trade Commission on May 11, 1987 and Southmark filed on May 14, 1987. The application was supplemented on at least two occasions after filing and not completed until approximately May 23, 1987. The Federal Trade Commission notified the seller on June 17, 1987 that it would take no action to stop the sale and purchase. It had not yet been possible to obtain the consent to the sale of all Shoreline Properties partners.

13. All required consents to the Agreement of Sale and Purchase necessary for the sale of all twenty-eight nursing homes, except for the sale of the nursing home operated by CBCC, Inc., were obtained between April 1, 1987 and April 3, 1987. *See* Exhibit No. B, at 39-51. The required consents for the sale of the nursing home operated by CBCC, Inc. were obtained only after negotiations between the Shoreline partners and a cash advance to one partner to set off against his proportionate distribution under the Agreement of Sale and Purchase. The last consent required for the sale of the nursing home operated by CBCC, Inc. was obtained on June 24, 1987, and the Agreement of Sale and Purchase was executed thereafter by all of the Shoreline partners.

14. During the negotiations which culminated in the Agreement of Sale and Purchase dated April 1, 1987, the parties discussed the claim of CBCC, Inc. for increased Medicaid payments which is the substantive dispute in the litigation currently before the Court. The parties agreed that the Medicaid reimbursement claim against the State of Oregon would remain the property of CBCC, Inc., and the

claim was not one of the assets sold by CBCC, Inc. or purchased by Southmark. The Agreement of Sale and Purchase excluded all accounts receivable from the assets sold to and purchased by Southmark. In pertinent part, the Agreement provides:

> Uncollected rents and other sums payable under the Leases which have accrued prior to the Adjustment Date [i.e., April 1, 1987] shall not be prorated at the Closing. . . . All rents and patient charges received by Purchaser from governmental agencies under governmental reimbursement programs shall be applied first to any outstanding amounts due therefrom to Seller with respect to each patient covered by such payment and thereafter to such amounts as are due to Purchaser. Nothing in this Paragraph A(iv) shall restrict Seller's right to collect delinquent patient charges or rents directly from a tenant by any legal means or shall obligate Purchaser to attempt to collect such delinquent patient charge or rents on Seller's behalf.

See Exhibit B, § IX, ¶ A(iv) at 29. The Agreement of Sale and Purchase defines "leases" to mean the admission agreements specifying the payment rate and payor (e.g., Medicaid, Medicare, private) for each patient. *See* Exhibit B, § III, ¶ L at 7.

15. The sale and purchase of the nursing home operated by CBCC, Inc. closed on June 30, 1987. Attached on Exhibit C is the Warranty Deed executed by Shoreline properties conveying the real property utilized by CBCC, Inc. to Southmark's assignee, Coos Bay Associates Limited Partnership. Attached as exhibit D is the Bill of Sale and Assignment of all personal property associated with the nursing home's operations.

16. Ownership of CBCC, Inc. was not sold or transferred to Southmark. CBCC, Inc. continues to be owned

by the same shareholders who owned the corporation prior to the transaction with Southmark. Don R. Bybee continues to serve as president of CBCC, Inc. The sole effect of the transaction with Southmark was to transfer the nursing home assets and operations from CBCC, Inc. to Southmark. The principle assets owned by CBCC, Inc. and Shoreline Properties are the right to the sale proceeds arising under the Agreement of Sale and Purchase and the right to collect certain receivables resulting from services rendered prior to April 1, 1987. CBCC, Inc. no longer has the capacity to provide nursing or related services to beneficiaries of the Oregon Medicaid Program. CBCC, Inc.'s only outstanding claims against the Oregon Medicaid Program are for accrued liabilities attributable to underreimbursement for care and services rendered prior to July 1, 1987, the date ownership of the nursing home was transferred to Southmark. Effective April 1, 1987, CBCC, Inc. had assigned its right to all revenues to Southmark or its assignee under the Management Agreement.

JAMES C. GRIGGS
HARLAND, RITTER, SAALFELD,
GRIGGS & GORSUCH,
a Professional corporation
693 Chemeketa Street N.E.
Salem, OR 97308

STATE OF OREGON
COUNTY OF MARION } ss.

The foregoing instrument was acknowledged and sworn before me this day of July, 1987, by James C. Griggs.

Before me:

Notary Public for Oregon
My Commission Expires: _____

ROBERT J. SAALFELD
HARLAND, RITTER, SAALFELD,
GRIGGS & GORSUCH,
a Professional corporation
693 Chemeketa Street N.E.
Salem, OR 97308

STATE OF OREGON
COUNTY OF MARION } ss.

The foregoing instrument was acknowledged and sworn before me this day of July, 1987, by Robert J. Saalfeld.

Before me:

Notary Public for Oregon
My Commission Expires: _____

Appendix B

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1419

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon corporation; Guardian Ad Litem; HANNAH SCHWANKE, Guardian At Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

AFFIDAVIT OF ROBERT M. DECKER

Robert M. Decker being duly sworn to law deposes and states as follows:

1. I, Robert M. Decker, currently hold the position of Vice President-Salem Division with National Heritage, Inc. ("NHI"). National Heritage, Inc., a wholly owned subsidiary of Southmark Corporation, manages the nursing home previously operated by Coos Bay Care Center, Inc. ("CBCC, Inc.") on behalf of Southmark and its assignee, the Coos Bay Associates Limited Partnership.

2. Prior to April 1, 1987 I held the position of Executive Vice President of Chartham Management. Don R. Bybee served as president of Chartham Management.

Chartham was in the business of operating and managing nursing homes. Chartham provided management services to CBCC, Inc.

3. I was involved in the negotiations related to the sale and purchase of twenty-eight nursing homes, including the nursing home formerly operated by CBCC, Inc., by Southmark pursuant to the Agreement of Sale and Purchase described in the Joint Affidavit of James C. Griggs and Robert J. Saalfeld. One part of my duties and responsibilities at Chartham and, after April 1, 1987, at NHI was to file appropriate notices with the State of Oregon reflecting the change of ownership of the nursing home formerly operated by CBCC, Inc. Such notice was necessary to obtain relicensure in the name of the new owner, to terminate the Medicaid "provider agreement" held by CBCC, Inc. and to secure a new "provider agreement" in the name of the new operator authorizing the nursing home to receive payment from the Oregon Medicaid Program for care and treatment provided to beneficiaries of such Program.

4. Attached as Exhibit A is a letter dated March 27, 1987 from me (as Executive Vice President of Chartham Management) to the Health Division, State of Oregon. The letter formally notifies the state that a letter of intent has been signed to sell the nursing home formerly operated by CBCC, Inc. and requests an application for relicensure.

5. Attached as Exhibits B and C are two letters dated April 15, 1987 and June 23, 1987 from me (as Vice President-Salem Division of NHI) to the Health Division, State of Oregon providing notifications of the purchase by Southmark, the purchase price and the anticipated closing date.

6. Attached as Exhibit D is the application dated April 17, 1987 to relicense the nursing home formerly operated by CBCC, Inc. in the name of the new operator. The application indicates that relicensure is necessary due to the change in ownership which was then expected to occur on June 1, 1987.

7. Attached as Exhibit E is "Long-Term Care Facility Request for Certification in the Medicare and/or Medicaid Program" dated April 9, 1987. The request for certification to participate in the Oregon Medicaid Program was submitted to obtain Medicaid certification in the name of the new operator because the change of ownership which occurred as a result of the sale by Shoreline properties and CBCC, Inc. to Southmark automatically terminated the nursing home's existing Medicaid provider agreement and its right to payment for care and services rendered to beneficiaries of the Oregon Medicaid Program.

8. Attached as Exhibit F is the "Disclosure of Ownership and Control Interest Statement" filed on behalf of Southmark and its assignee, Coos Bay Associates Limited Partnership along with the request for Medicaid certification. The Disclosure statement is a prerequisite to Medicaid certification. The form and its attachments indicates that the nursing home changed ownership effective July 1, 1987, that the nursing home is now owned by Coos Bay Associates Limited Partnership and that the nursing home is managed by NHI. As the disclosure statement indicates, no person or entity which held any ownership or operational interest in CBCC, Inc. or in the nursing home CBCC, Inc. formerly operated owns any part of the nursing home's new operator or owner.

9. Relicensure and recertification of nursing homes in Oregon following a change in ownership is relatively routine and is usually handled as an administrative matter. The new license and provider agreement for the nursing home formerly operated by CBCC, Inc. has not yet been received. Final application for the license was not possible until June 23, 1987, however. I anticipate receiving the new license and provider agreements effective July 1, 1987 in the immediate future. New licenses and provider agreements have been received already for all other nursing homes purchased by Southmark pursuant to the Agreement of Sale and Purchase dated April 1, 1987. Of course

the applications for relicensure and or new provider agreements were able to be filed much earlier than for the nursing home formerly operated by CBCC, Inc. because the other sales were certain to occur.

Further affiant sayeth not.

Robert M. Decker

STATE OF UTAH
COUNTY OF SALT LAKE } ss.

The foregoing instrument was acknowledged and sworn to before me this day of July 1987.

Before me:

Notary Public for Utah
My Commission Expires: _____

Appendix C

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

86-1419

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

vs:

COOS BAY CARE CENTER, an Oregon corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

AFFIDAVIT OF DON R. BYBEE

Don R. Bybee being duly sworn according to law deposes and says as follows:

1. I am the president of Coos Bay Care Center, Inc. ("CBCC, Inc."), the respondent in this action. I have been a principal stockholder in CBCC, Inc. since its formation. I have served as president of CBCC, Inc. since the corporation was formed. In addition, I am a fifty percent partner in Shoreline Properties, an Oregon partnership. Prior to July 1, 1987, Shoreline Properties owned the land, buildings, fixtures and most of the equipment (the "assets") utilized by CBCC, Inc. to provide nursing home care and service. Prior to July 1, 1987 the assets were leased by Shoreline to CBCC, Inc. The assets of Shoreline properties

were purchased by Southmark Corporation on July 1, 1987 and assigned to Coos Bay Associates Limited Partnership.

2. The Agreement of Sale and Purchase dated April 1, 1987 covering the sale of the assets of Shoreline Properties and the nursing home operations of CBCC, Inc. is attached as Exhibit B to the Joint Affidavit of James C. Griggs and Robert J. Saalfeld filed in this action. Section XI, paragraph A(iv) (page 29) provides that patient charges (i.e., rents) and other sums payable by or on behalf of patients shall not be prorated at the closing. The Agreement also provides that payments received from governmental reimbursement programs shall be applied first to reduce accrued liabilities due the Seller for each patient covered by the payment, with the balance being paid to the purchaser. Further, the Agreement specifically permits the Seller to pursue legal relief for delinquent claims for accrued liabilities.

3. It was and is my understanding that the purpose of Section IX, paragraph A(iv) was to reserve accounts receivable due from or on behalf of patients, including claims against state Medicaid programs, to the Seller, in this instance CBCC, Inc. It is my understanding and it was my intention that the reimbursement claim at issue in this litigation would remain an asset of CBCC, Inc. In fact, during the negotitions, the status of the reimbursement claim at issue in this litigation was discussed with representatives of Southmark, and it was agreed that the claim would remain the property of CBCC, Inc. and not be transferred to Southmark or its assignee.

4. Because the Shoreline assets formerly used (pursuant to lease) by CBCC, Inc. to provide nursing care and services reimbursable by the Oregon Medicaid Program were sold to Southmark and changed ownership effective July 1, 1987, CBCC, Inc. no longer provides any services for which payment is available from the Oregon Medicaid Program. CBCC, Inc.'s only remaining reimbursement claim against the Oregon Medicaid Prog-

ram is for accrued liability attributable to under-reimbursement paid for care and services provided prior to July 1, 1987.

Further affidavit sayeth not.

_____

Don R. Bybee

STATE OF OREGON
COUNTY OF MARION } ss.

The foregoing instrument was acknowledged and sworn before me this day of July, 1987, by Don R. Bybee.

Before me.

_____

Notary Public for Oregon
My Commission Expires: _____

No. 86-1419

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, INC., an Oregon Corporation;
HANNAH SCHWANKE, Guardian Ad Litem for
David and Steven Gibbs; and SANDI
WATSON-STOWELL, Guardian Ad Litem for Tami Watson

Respondents.

AFFIDAVIT OF SERVICE OF RESPONDENT'S MOTION TO DISMISS

Janice L. Hoffman, being duly sworn, deposes and says:

I am a member in good standing of the Bar of the District of Columbia Court of Appeals. On this 24th day of August, 1987, I instructed Ms. Beverly A. Patton, my secretary, to serve via United States mail, first class, postage prepaid, three true and correct copies of Respondent's Motion to Dismiss on each of the following counsel of record for the parties and amicus:

Virginia L. Linder
Solicitor General
State of Oregon
400 Justice Building
Salem, Oregon 97310

Donald W. Lojek
LOJEK & HALL, CTD.
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Charles Fried
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DEPARTMENT OF JUSTICE
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Benna Ruth Solomon
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Corinne K.A. Watanabe
First Deputy Attorney General
State of Hawaii
State Capitol
Honolulu, Hawaii 96813

Ms. Patton subsequently reported to me that she had deposited the envelopes containing the service copies of Respondent's Motion to Dismiss in a mailbox in front of the United States Post Office located at 1111 - 20th Street, N.W., Washington, D. C. 20036 at 12:00 p.m. on that day.

I further attest that all parties required to be served have been served.

Respectfully submitted,

Janice L. Hoffman

Janice L. Hoffman
CASSON, CALLIGARO & MUTRYN
1233 20th Street, N.W.
Suite 800
Washington, D.C. 20036
(202) 778-1100

Counsel for Respondent
Coos Bay Care Center

District of Columbia)

Subscribed to and sworn before me this 21st day of August, 1987.

Beverly A. Patton
Notary Public

My Commission Expires: 4/30/91

Supreme Court, U.S.
FILED
SEP 11 1987
JOSEPH F. SPANIOL, JR.
CLERK

(10)

No. 86-1419

In the Supreme Court of the United States

OCTOBER TERM, 1987

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

RESPONSE IN OPPOSITION TO MOTION TO DISMISS

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HIPP

QUESTIONS PRESENTED

1. Whether change of a Medicaid provider's corporate owner moots litigation seeking both retroactive and prospective reimbursement relief when: (1) the claim for retroactive relief remains viable, although the plaintiff chooses to reverse positions on the claim; (2) the new corporate owner operates the same provider facility and is entitled to Medicaid reimbursement pursuant to a Medicaid provider agreement and "heavy care" addendum that are identical to those that are the subject of the litigation; (3) under federal law, the new corporate owner is assigned the former owner's provider status to ensure uninterrupted Medicaid benefits; and (4) the claims of the named plaintiff patients and putative class members are unaffected by the transfer of interest.

2. Whether this Court should dismiss the petition for certiorari on the basis of arguments that do not bear on the court's jurisdiction and that, under Rules 23 and 35, properly should have been but were not raised in opposition to the petition.

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PETITIONERS' RESPONSE IN OPPOSITION TO RESPONDENTS' MOTION TO DISMISS

Petitioners respectfully urge that the respondents' motion to dismiss the petition for writ of certiorari on grounds of mootness be denied. Alternatively, if the Court is inclined to find some merit in the motion, petitioners ask the court to postpone a ruling on it until oral argument and consideration on the merits. Finally, the nonjurisdictional grounds asserted in support of the motion should be summarily rejected.

ARGUMENT

I. The Controversy in This Case Is Not Moot.

Plaintiffs in this case consist of the former corporate owner of the Coos Bay Care Center, a Medicaid-certified intermediate care facility, and three patients who have resided or continue to reside there.[1] The patients and the former owner have sued the state seeking damages for past Medicaid reimbursement decisions that allegedly violated their federal statutory and constitutional rights; and they seek prospective declaratory and injunctive relief to require the state to reimburse at a higher level in the future. The patients sue both in their individual capacity and as representatives of a putative class of similarly situated patients at care homes throughout the State of Oregon.

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[1] For ease of reference, we refer to the patients themselves as plaintiffs, although their interests in fact are represented through guardians *ad litem*. David and Steven Gibbs, according to the state's records, continue to be patients at the Coos Bay Care Center facility, as implied but not expressly acknowledged in footnote 2 of the motion to dismiss. Tami Watson, also according to the state's records, now resides in an intermediate care facility in Medford, Oregon.

Coos Bay Care Center, Inc. (CBCC Inc.), without the concurrence or the participation of the patient plaintiffs,[2] moves to dismiss the petition for writ of certiorari on the theory that this case is now moot. It relies on the fact that on June 30, 1987, another entity, Southmark Corporation, purchased CBCC Inc.'s interest in the Coos Bay Care Center. CBCC Inc. indicates that, under the terms of the sale, it retains its interest in retroactive relief (damages measured by past under-reimbursement); but it now takes the position that the Eleventh Amendment bars that remedy and it therefore is not entitled to pursue the claim. As to prospective declaratory and injunctive relief, CBCC Inc. urges that the sale terminated any interest it may have had in future Medicaid reimbursement, thereby "mooting" the case.

Despite CBCC Inc.'s efforts to make it appear as though factual changes have mooted this case, the underlying controversy remains as vital as when the original complaint was filed. The factual circumstances that gave rise to this lawsuit are essentially unchanged. Coos Bay Care Center still is a Medicaid-certified intermediate care facility. It still is providing care to Medicaid-eligible patients. The facility continues in the same business, providing care to the same people. The state continues to reimburse for that care pursuant to the same base rate and heavy cost add-on rate policies and practices. Those policies and procedures continue to be applied to intermediate care facilities and their patients throughout Oregon. Nothing has changed except the beneficial ownership of the Coos Bay Care Center.

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[2] Respondent CBCC Inc. is careful in its motion to emphasize that it is filed only on behalf of the corporate plaintiff. *See* Motion to Dismiss, p. 1, n. 1. Evidently, documents to substitute new counsel in representing Hannah Schwanke (guardian *ad litem* for David and Steven Gibbs) are being prepared. *Id.* But counsel for CBCC Inc. does not indicate whether these patients are expected to join in the motion. Apparently, Tami Watson is not expected to be represented by new counsel.

CBCC Inc. builds its case for "mootness" through a variety of devices that do not demonstrate mootness at all. In fact, the motion to dismiss and supporting materials are a transparent attempt to call off an ongoing battle because, from the respondent's perspective, it is going badly. The very fact that CBCC Inc. has committed substantial resources to its effort to avoid an adverse precedent is compelling evidence that the controversy that sparked this case is alive and well. In its motion, CBCC Inc. concedes points on the merits that, before the lower courts, it forcefully resisted. It characterizes the patients' claims in a way that contradicts the position it took previously in this litigation, and in a way that simply is refuted by the complaint's express allegations. It ignores altogether the complaint's class action allegations and the interests of the putative class and the plaintiff representatives. Neither CBCC Inc. nor Southmark Corporation has availed itself of simple procedures for substitution and joinder of parties that are available. Instead, under the guise of "mootness," CBCC Inc. is actually attempting to avoid this Court's resolution of an issue of unquestioned public importance[3] that continues to have concrete significance to the provider, to the patients and to the state.

As demonstrated below, this Court should not grant the motion to dismiss. However, if the Court is inclined to find some merit in the motion at this juncture, we urge the Court to postpone its ruling. The posture of the case, given the variety of plaintiff interests at stake, is sufficiently complex and the factual ambiguities are sufficiently great that the Court should consider the motion after oral argument and along with the merits, as it has done in other cases. *See, e.g., NLRB*

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[3] The level of amicus interest and participation in this case amply demonstrates the importance, to patients, providers and states alike, of a resolution of the issue presented.

v. Insurance Agents' International Union, AFL-CIO, 361 U.S. 477, 500 n. 32 (1960).

A. Factual Background.

We do not question the basic factual information presented to the Court by CBCC Inc. in the motion to dismiss and the attached affidavits. As CBCC Inc. represents, it sold its interests in the Coos Bay Care Center facility on June 30, 1987. Around mid-April, it and the purchaser, Southmark Corporation, initiated the processes for relicensure and reissuance of the provider agreement to Southmark.[4] As we understand it, although the transfer of interest did not occur until the end of June, Southmark in fact assumed management of the facility on April 1, four months before.

Under the terms of the sale agreement, CBCC Inc. retains its interest in all accounts payable accruing prior to April 1, 1987. Amounts accruing after that time apparently are Southmark's. Thus, although CBCC Inc. argues that it alone holds an interest in amounts owed to the care center during the period of its ownership, that does not appear to be entirely the case. Moreover, the agreement expressly provides that all amounts owed by governmental agencies under governmental reimbursement programs are first due to CBCC Inc. with respect to outstanding amounts due to it for each patient covered by the payment and "thereafter to such amounts as

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[4] In footnote 5 of the motion, CBCC Inc. suggests that "petitioners" were notified of the intent to sell on several occasions, beginning in late March. The ambiguous reference to "petitioners" suggests that perhaps the Oregon Attorney General, shortly after filing the petition for certiorari in this case, was so notified. That is not the case. CBCC Inc. notified the client agency for the sole purpose of beginning the routine paperwork that would result in transfer of the provider agreement to the new corporate owner. As counsel for the agency in this litigation, we were not advised of the transfer of interest until some time after the sale, while we were in the final stages of preparation of our brief on the merits. We were then contacted by new counsel for CBCC Inc. who informed us of the recent sale and the fact that the representation was to be transferred to them. We received no formal confirmation of those facts from either the present or former counsel prior to the filing of the motion to dismiss.

are due to Purchaser." (*See* verbatim portion of sale agreement, quoted in Joint Affidavit, Motion to Dismiss at 7a).

In addition to the factual information discussed by CBCC Inc. in its motion, there are further relevant facts apparent from the information CBCC Inc. sets out and available through the state's records. It does not appear that there has been any significant change in the care center's business operations, its staff or its patients. The care center continues to be a certified Medicaid provider. In fact, Southmark is operating the facility pursuant to the certification obtained by CBCC Inc. As discussed *infra*, it is entitled to do so pursuant to federal regulations until that certification expires. In anticipation of the transfer of ownership, Southmark sought relicensing of the facility to carry on the same patient services previously provided by CBCC Inc. As acknowledged by CBCC Inc. (*See* Decker Affidavit at 12a), relicensing is a routine, administrative matter upon transfer of ownership. The state agency has issued to Southmark a provider agreement and heavy cost addendum that, in all material respects, are identical to those previously issued to CBCC.[5] These agreements are attached as Appendixes A and B to this brief. The agreements differ only in that they substitute Southmark's corporate ownership interests for those of CBCC Inc. Southmark will be entitled to the same provider rates as were applied to CBCC Inc. and the provider agreement is dated so that it is in force for the full time period remaining under CBCC Inc.'s agreement.

Two of the three patient plaintiffs and class representatives, David and Steven Gibbs, continue to reside in Coos

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[5] The provider agreement with Southmark actually was issued to "Coos Bay Associates Limited Partnership." *See* Appendix A. Southmark is referred to in this brief instead of Coos Bay Associates because, as respondents note in their motion, page 4, Southmark controls Coos Bay Associates.

Bay Care Center. There is nothing in the state agency's records to suggest that their care needs or status have changed in any way, and CBCC Inc. does not assert any change. The state's records further reflect, as CBCC Inc. points out (Motion to Dismiss, n. 2), that Tami Watson no longer is a patient at Coos Bay Care Center. However, she continues to reside in an Oregon intermediate care facility certified as a Medicaid provider. The facility operates under the same standard provider agreement and heavy cost addendum involved in this lawsuit, and Tami Watson now is listed as a heavy cost-eligible patient.

Finally, even the staff of the care home appears to have remained largely the same. For example, Robert M. Decker previously was Executive Vice President of Chartham Management, a company apparently connected with and which managed the facility for CBCC Inc. (*See* Decker and Eybee Affidavits, Motion to Dismiss). On April 1, 1987, before the transfer of interest but simultaneous with Southmark's assumption of the facility's management, Robert Decker became a Vice-President of National Heritage, Inc., the subsidiary of Southmark that assumed (and retains) that management responsibility. Mr. Decker continues in that capacity. (*See* Decker Affidavit, Motion to Dismiss at 10a-11a).

B. The Claims for Retrospective Relief.

The change in the care facility's corporate ownership does not even arguably extinguish any of the plaintiffs' or the putative classes' interest in damages based on alleged under-reimbursement. CBCC Inc. does not assert that the claims for restrospective relief are moot. Instead, it takes the legal position that the Eleventh Amendment bars a federal court from awarding monetary damages out of a state's treasury. Its argument, however, confuses the question of its entitlement to relief with the question of whether a change of facual circum-

stances has eliminated the existence of a legally cognizable controversy.

"Mootness" simply is the wrong analytic label. CBCC Inc.'s position on the Eleventh Amendment question demonstrates only that it no longer believes in the legal position that it advanced before the lower courts in this case. Indeed, it pressed the opposite argument at some length before the Ninth Circuit (Reply Br. at pp. 14-18), and prevailed. Without even acknowledging the inconsistency between its present and prior positions, it now reverses itself and essentially concedes that the state is and was correct all along. But the Eleventh Amendment issue goes to the merits of whether the district court correctly dismissed the complaint for failure to state a cause of action, and whether the Ninth Circuit correctly reversed that judgment and remanded this case for trial. The Eleventh Amendment thus goes to the *substantive* question of the district court's jurisdiction, rather than to this Court's jurisdiction to review that issue. To view a concession on a legal controversy as "mooting" the case would mean that litigants freely could manipulate this Court's jurisdiction merely by altering their legal arguments on certiorari review. That cannot be correct. *Cf. City of Mesquite v. Alladdin's Castle, Inc.*, 455 U.S. 283, 289 (1982) (mere voluntary cessation of a challenged practice does not deprive a federal court of power to determine the legality of the practice). While the state unquestionably agrees with the substance of CBCC Inc.'s Eleventh Amendment argument, the issue cannot be decided as one of "mootness."

Moreover, at this juncture, the position of the patient plaintiffs, both individually and in their representative capacity, must be assumed to be unchanged—*i.e.*, that they are entitled to retrospective relief. And although CBCC Inc. asserts that it has retained all interest in the "accounts payable," and thus in any damages claim, that is not at all

clear. The express provisions of the agreement appear to assign those rights to Southmark for the four-month period that CBCC Inc.'s ownership continued but Southmark managed the facility. If this complaint were dismissed today, Southmark could freely sue the state tomorrow on essentially the same factual allegations and the identical legal theories advanced originally by CBCC Inc. In short, the facts giving rise to this controversy are not significantly changed and CBCC Inc.'s change of legal theories does not drain this case of its importance in determining the parties' rights and liabilities.

C. The Claims for Prospective Relief.

1. CBCC Inc.'s interests.

On the question of injunctive and declaratory relief, CBCC Inc. correctly points out that the sale of the care facility terminated any prospective interest it had in future Medicaid reimbursement levels. Thus, it argues that it no longer is suffering any ongoing injury from the state's conduct and has no claim which can be remedied by prospective relief, thereby mooting the litigation.

Notwithstanding the superficial appeal this argument may have at first glance, given the actual circumstances, at most there is a basis for the substitution or joinder of Southmark as a party. Under Federal Rule of Civil Procedure 25(c),[6] an action may be continued by or against the original party, notwithstanding the transfer of interest. Alternatively, the court upon motion may direct the person to whom the interest is transferred to be substituted or joined with the original party. Thus, if this case were returned to the district court for

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[6] Federal Rule of Civil Procedure 25(c) provides:

> In case of any transfer of interest, the action may be continued by or against the original party, unless the court upon motion directs the person to whom the interest is transferred to be substituted in the action or joined with the original party. Service of the motion shall be made as provided in subdivision (a) of this rule.

trial, CBCC Inc. despite the transfer would be able to maintain its action, although either plaintiffs or the state could move to have Southmark joined or substituted as a party.[7]

As the rule implicitly recognizes, litigation is not "mooted" by a transfer of interest alone. Yet that is all that has occurred here, both as a matter of fact and as a matter of law. Under the governing federal regulations, states are required to place the new owner in the exact position of the former owner. 42 C.F.R. § 442.14(a) provides:

> When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

Subsection (b) of the same federal rule further requires that the new owner is assigned the agreement subject to "the terms and conditions under which it was originally issued" including any special corrective conditions attached to the original agreement and the original agreement's expiration date.[8]

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[7] Under CBCC Inc's analysis, this case is moot because the plaintiff chooses not to pursue a claim where the federal rules expressly permit it to do so. If CBCC Inc. wished to press its claim despite the transfer of interest, defendants could not cause the case to be dismissed as moot. At most, defendants could seek joinder of Southmark. Thus, application of the mootness doctrine should not be dependent on one party's decision regarding litigation strategy.

[8] 42 C.F.R. § 442.114(b) states:

> An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:
>
> (1) Any existing plan of correction.
>
> (2) Any expiration date.
>
> (3) Compliance with applicable health and safety standards.
>
> (4) Compliance with the ownership and financial interest disclosure requirements of §§ 455.104 and 455.105 of this chapter.
>
> (5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.
>
> (6) Compliance with any additional requirements imposed by the Medicaid agency.

Accordingly, here, Southmark has simply stepped into CBCC's shoes. The facility's certification as a Medicaid provider, one of the most important Medicaid procedural hurdles to clear, is unchanged. Southmark will operate under that certification just as did CBCC Inc. until the annual renewal comes due. Consistent with the federal regulation, the state agency has assigned CBCC Inc.'s provider agreement to Southmark. Thus, as a routine administrative matter, the state has issued in Southmark's name a standardized provider agreement and heavy cost addendum identical to those previously in place when CBCC Inc. was the beneficial owner.

Although CBCC Inc. chooses to characterize this as a "new" provider agreement, it is new only in the sense that it now reflects the recent purchaser's ownership interests. The transfer of interest between CBCC Inc. and Southmark therefore simply is not a fact that extinguishes the prospective interests at stake in this litigation. None of the relevant facts has changed. The business (Coos Bay Care Center) continues to be a certified Medicaid intermediate care facility. It continues to care for quadriplegic patients, and it continues to be entitled to the heavy cost add-on to its rate for those patients who qualify under the state's Medicaid program. The state's Medicaid plan provisions and heavy cost policies and practices have not changed. In short, to whatever extent the plaintiffs have ever had an actionable federal claim for a particular reimbursement level for certain patients (which is the issue to be resolved in this case), the facts giving rise to that claim are unchanged.

It may be that if this case were returned to the district court for trial, neither CBCC Inc. nor Southmark would choose to devote their resources to pursuing their claims. But their ability voluntarily to dismiss the suit at the trial level is beside the point. There should be no question that the "underlying question persists and is agitated by the continuing

activities and program of petitioners. . . ." *Carroll v. President and Commissioners of Princess Anne*, 393 U.S. 175, 179 (1968). Under such circumstances, the mere transfer of ownership interest in the Coos Bay Care Center does not moot this controvery. *Cf. De Veau v. Braisted*, 363 U.S. 144, 146 n. 1 (1960) (labor controversy not mooted by fact that original union was disbanded and all employees under its jurisdiction came under the jurisdiction of a new local); *NLRB v. Insurance Agents*, 361 U.S. at 500 n. 32 (merger of respondent union with another union did not moot labor dispute; court would treat both unions as parties on review).

2. The patient plaintiffs' individual and representative interests.

In support of its mootness arguments, CBCC Inc. says very little about the individual patient plaintiffs, and all but ignores the class action allegations of the complaint. By way of footnote, CBCC Inc. simply attempts to dismiss the patient plaintiffs' claims as dependent on their status as "third party beneficiaries of the now-terminated provider contract." (Motion to Dismiss, n. 8). This ignores the unequivocal allegations of the complaint and also the position that plaintiffs, including CBCC Inc., have taken in the lower courts and before this Court.

In their complaint, plaintiffs alleged that "David and Steven Schwanke [*sic*] and Tami Mauer [*sic*] are third party beneficiaries of this agreement and may maintain an action upon it." (Complaint, J.A. at 4). That allegation was necessary in order for those plaintiffs to join in the pendent state breach of contract claim, set out as plaintiffs' second cause of action. But the complaint went on to allege that the patient plaintiffs are heavy care patients; that "heavy care" patients are those who require significantly more or greater care than ordinary patients due to medical or developmental problems; that there are a number of heavy care patients at Coos Bay

Care Center and similar institutions throughout Oregon; and that these patients do not receive appropriate care due to the state's refusal to reimburse health care providers appropriately for their care. (*Id.* at 5-6). Plaintiffs added in their class action allegations that they are representative of a class of heavy care patients that exceeds 100 patients statewide. (*Id.* at 7).

On their individual behalves and on behalf of the putative class, plaintiffs pleaded that the state's reimbursement policies directly violated their federal statutory and constitutional rights. (*Id.* at 6). In the lower courts, plaintiffs urged that the patients have an independent right under federal law to sue over Medicaid reimbursement levels,[9] and they prevailed on that argument in the Ninth Circuit.[10] Moreover, they vigorously reasserted that position before this Court in opposing the petition for writ of certiorari.[11] CBCC Inc.'s position in the motion to dismiss is thus at odds with the position that it has taken at every other stage of this case. CBCC Inc.'s attempts to disassociate itself with its own pleadings and legal arguments in an effort to moot this case are disingenuous at best.

The individual plaintiffs have not joined in CBCC Inc.'s arguments. They do not disclaim either their right or intention to pursue both prospective and retroactive relief, on their own or the putative class's behalf. Nor is there any theory on which the transfer of corporate ownership could moot their claims. At most, David and Steven Gibbs would have to amend the complaint to refer to the new corporate owner where relevant references to CBCC Inc. previously appeared. Tami Watson's interests in prospective relief may

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[9] *See, e.g.*, App. Br. at pp. 16-28; Reply Br. at p. 4.

[10] *See* Pet. App. at pp. App-4 - App-5.

[11] *See, e.g.*, Br. Opp. at pp. 4, 8 and 12.

now be moot, given her classification as a heavy cost patient, but her claim for damages is not. CBCC Inc. has not presented the Court with any basis upon which to conclude that those patients do not have a continuing personal stake in their individual claims, and has not suggested why they cannot continue as representatives of the putative class. Nor has CBCC Inc. pointed to any theory on which the putative class interests in this litigation are extinguished. CBCC Inc. mentions only that the class "does not appear" to have been certified. (Motion to Dismiss, n. 3). Certification, however, was never denied. The complaint was dismissed for failure to state a claim; the district court never reached the issue of certification. For present purposes, the action must be assumed to be properly pleaded as a class claim. *See, e.g., Gatling v. Butler*, 52 F.R.D. 389, 395 (D. Conn. 1971) (citing cases); *Washington v. Wyman*, 54 F.R.D. 266, 270-71 (S.D. N.Y. 1971) (same). So long as the patients' representational interests are not moot, they may continue to press the class claim. *See generally United States Parole Commission v. Geraghty*, 445 U.S. 388 (1980). Thus, the patient plaintiffs continue to have an unquestioned interest in resolving this controversy, both individually and as class representatives.

Accordingly, the change of corporate owners simply is not a fact that completely and irrevocably eradicates the prospective interests of the patients or the provider. CBCC Inc.'s disinclination to seek to substitute the new corporate owner as a party should not be permitted to frustrate this Court's review; nor should that result follow from CBCC's willingness to ignore the interests that the patients, individually and as putative class representatives, have asserted from the outset. The state's regulations, policies and practices for heavy cost reimbursement are unchanged. The only real change is in CBCC Inc.'s and the new provider's strategy in pursuing their claims before this Court. That strategy should not

impede review of an actual controversy of unquestioned public importance and it should not divest the state of the opportunity to regain the benefit of a judgment that was correctly entered and would have important *res judicata* and *collateral estoppal* effects if reinstated today.

II. None of the Other Arguments Advanced by CBCC Inc. are Properly Raised.

CBCC Inc.'s remaining arguments are not properly raised or before the Court. The arguments urge that certain issues either were not preserved below or were not clearly reached or decided by the lower courts, and that the case therefore does not warrant this Court's review. All of the arguments are predicated on wrong characterizations of the record, misunderstandings of the issues presented, and incorrect conclusions about the lower court's opinion and the effect its opinion has on the issues this court appropriately may reach.

More important, however, for purposes of this motion, none of these arguments bears on jurisdiction; all are matters that could have been advanced in the plaintiffs' Brief in Opposition to the Petition for Writ of Certiorari, but were not. Under this Court's rules, they are improperly raised in the motion to dismiss. *See* S. Ct. Rules 22.3 and 35.5. They therefore should be summarily rejected.

CONCLUSION

For the reasons set forth above, respondent Coos Bay Care Center, Inc.'s motion to dismiss the writ of certiorari should be denied.

Respectfully submitted,
DAVE FROHNMAYER
Attorney General of Oregon
WILLIAM F. GARY
Deputy Attorney General
VIRGINIA L. LINDER
Solicitor General
Counsel for Petitioners

APPENDIX A

Nuring Facility Contract

Part 1. Signators

This contract is between the State of Oregon, by and through the Department of Human Resources, Senior Services Division, hereinafter referred to as the "Division" in order to procure Nursing Facility services and

COOS BAY ASSOCIATES LIMITED PARTNERSHIP

Coos Bay Care Center

2625 Koos Bay Blvd.

Coos Bay, OR 97420

hereinafter referred to as "Contractor."

This ☐ SNF contract ☒ ICF contract ☐ extension ☒ Heavy Cost addendum ☐ Contiguous Area contract begins 07-01-87 and ends 10-31-87; however, it is not effective until signed by the Senior Services Division of the State of Oregon.

The following listed parts, together with attachments referred to therein and attached, form the whole of this contract.

Contract Documents

Place an X in the appropriate box(es):

- ☒ Part 1. Signators.
- ☒ Part 2. Skilled Nursing Facility and/or intermediate Care Facility Contract Conditions, paragraphs 1 through 9, pages 1 through 6 attached.
- ☐ Part 3. Extension of Nursing Facility Contract, paragraph 1 attached.
- ☒ Part 4. Heavy Cost Addendum, paragraphs 1 through 2 attached.
- ☐ Part 5. Area contiguous to Oregon, conditions, 1 page attached.

[Signatures and copy distribution omitted in printing]

PART 2
SKILLED/NURSING INTERMEDIATE CARE

1. Definitions: Nursing Facility, as used in this part, means a Skilled or Intermediate Care Facility, licensed and certified to provide care under Federal and State laws, rules and regulations under Title XVIII or Title XIX.

2. Pursuant to ORS 184-750, the Department of Human Resources, through Adult and Family Services Division (AFS), is the agency responsible for administering the Medical Assistance Program (Title XIX) in Oregon. By agreement, the Senior Services Division administers the Title XIX Long-Term Care Services Program.

3. Section 1902(a)(27) of Title XIX of the Social Security Act requires a state to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance. The purpose of this agreement is to assure that the facility is providing services appropriate to the needs of the clients in return for payment by the agency for services purchased and provided.

4. To participate in the Oregon Medical Assistance Program (Title XIX) a Nursing Facility must: (1) be licensed at the appropriate skill level as a nursing facility or hospital under the laws of Oregon; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing facility administrator who holds a current Oregon license or by a hospital administrator; and (4) be 100% Medicaid certified or as specified in OAR 411-70-010 and meet on a continuing basis federal standards for participation in the Title XIX Medical Assistance Program. All conditions apply to clients who are receiving assistance under Title XIX or the General Assistance Program.

5. Contractor has filed an application with the State Senior Services Division to provide, as a Nursing Facility, health-related care and services to any and all persons eligible, and referred by SSD/AAA for the Title XIX Medical Assistance Program. The approved application is attached hereto and by this reference made a part of this Agreement.

CONTRACTOR AGREES TO:

A. Comply with all Oregon Administrative Rules and state statutes applicable to the operation of Nursing Facilities under the Title XIX Long-Term Care Facility Services Program.

B. Comply with all applicable sections of the Title XIX Social Security Act and amendments thereto and applicable regulations.

C. Inform Division/Type B Area Agency on Aging (AAA) in writing on the day of admittance or discharge when clients covered under the Title XIX Program are admitted to and discharged from the Nursing Facility.

D. Notify Division/Type B AAA on the first working day after transfer of the client to an acute care hospital and prior to therapeutic leave.

E. Notify Division/Type B AAA in writing on the date the license is changed or of any change in operating license issued by the State Senior Services Division.

F. Meet the requirement of Residents' Bill of Rights as outlined in 42 CFR 442.311.

G. Provide cooperative methods and procedures relating to the utilization of care and services, as may be necessary to safeguard against unnecessary utilization of such care and services.

H. Submit annual cost statements within the established time limits and using the forms and instructions specified in the Title XIX Long-Term Care Facility Services Guide.

I. Submit billings for clients covered by this Agreement showing correct resident day counts, resident income, and payment rates consistent with dates and amounts, prior authorized by the Division/Type B AAA.

J. Contractor will maintain detailed, complete, and accurate records of the care provided and the costs of the care. Records of services and costs will be made avail-

able to the Division upon request, including information requested by telephone. The Division/Type B AAA has the right to photocopy any records, including incident reports and personnel records, deemed by the division necessary to carry out state and federal statutes and rules. The Contractor shall retain medical records for a minimum of seven years and financial records for a minimum of three years or from the date all audit questions have been resolved, whichever period is the longest. Records will include at least the following:

1) Records as required by Section 1905(c) and (d) of Title XIX of the Social Security Act and any amendments thereto;

2) Records of all treatments, drugs, and services for which Contractor has been or is to be paid under the Title XIX Program, including the authority for and the date of administration of such treatment, drugs, or services;

3) All other records as may be found necessary by Division in compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services, or by the Division, or as a result of a judicial action.

K. Provide access to residents as may be found necessary by Division/Type B AAA to comply with state and federal laws, rules, and regulations. This includes professional review organizations contracting with the Division.

L. Accept payment from the Division as payment in full for those services, goods, and products included in the all-inclusive per diem rate, with the understanding that: Whosoever knowingly and willfully: (1) charges for any such service, goods, or products in excess of the all-inclusive per diem rate established by the Division; or (2) charges, solicits, accepts or receives, in addition to the amount paid by the Division, any gift, money, donation, or other consideration as a pre-condition of admitting a client to a Nursing Facility, or as a require-

ment for the client's continued stay in such a facility, shall be guilty of a (federal) felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years or both.

M. Division may withhold payment because of violation of this Agreement by Contractor until the violation is remedied. If violations are not remedied in the time specified by Division in the violation notice, Division may terminate this Agreement upon 30 days' written notice.

N. Not to employ any person in a management or supervisory capacity who has been convicted of a criminal offense involving Medicaid or Medicare laws, rules, or regulations.

O. Assure that neither Contractor nor its employes shall aid, abet, or engage in any act detrimental to the health, safety, or welfare of the clients or in the abuse of clients under its care; nor shall Contractor hire or retain in employment persons whom it knows or should know were convicted for such practices.

P. Meet conditions for participation as a Nursing Facility required by Federal Regulations 42 CFR 442.101 and 442.300, and meet CFR 442.311 and 442.320 relating to patient rights and protection of patient funds.

Q. Notify the Division/Type B AAA of any client acquiring a change in level of nursing facility care, and cooperate with the division/AAA in making alternative plans with the client.

R. Comply with Title VI, Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

S. Comply with Executive Order 11246 entitled Equal Employment Opportunity as amended by Executive Order 11375 and as supplemented in Department of Labor Regulation 41 CFR Part 60. All subcontracts shall also comply with these provisions.

T. Maintain fiscal records and other records pertinent to this contract. All fiscal records shall be maintained

pursuant to accepted accounting standards and other records shall be maintained to the extent necessary to clearly reflect actions taken. Contractor further agrees to provide access to any books, documents, papers, and records of Contractor which are pertinent to this contract and, further, to allow the making of excerpts, transcripts, or performing audits or examinations thereof. Such access shall be freely allowed to state and federal personnel and their duly authorized agents.

All such records shall be retained and kept accessible for three years following final payment and conclusion of all pending matters. All subcontracts shall also comply with these provisions.

In addition, Contractor and its agents, employes, and subcontractors shall maintain all such records fully confidential. Such confidential status shall be in compliance with the requirements stated in 45 CFR 205.50 and 42 CFR 431 subpart F.

U. Abide by all mandatory standards and policies which relate to energy effeciency and which are contained in the State of Oregon energy conservation plan which was issued in compliance with the Energy Policy and Conservation Act (PL 94-165). All subcontracts shall also be in compliance with the foregoing.

V. Ensure that if the sum payable under this contract exceeds or may exceed $100,000, the Contractor shall provide the State of Oregon a written assurance the Contractor will comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act ($2 [*sic*] USC 1857 H) Section 508 of the Clean Water Act (33 USC 1368) Executive Order 11738 and Environmental Protection Agency regulation (40 CFR Part 15), and further, Contractor agrees to promptly report all infractions to the State of Oregon, the Federal Grantor Agency, and to the U.S. Environmental Protection Agency. All subcontracts shall also be in compliance with these provisions.

7. DIVISION AGREES TO:

A. Make payments to Contractor in accordance with all Oregon Administrative Rules applicable to Nursing

Facilities under the Title XIX Long-Term Care Facility Services Program, as soon as feasible after a proper claim is submitted and approved.

B. Give Contractor reasonable notice in writing of any change related to the Division Title XIX Medical Assistance Program that will affect Contractor.

8. DIVISION/TYPE B AAA AGREES TO:

A. Prior authorize payments for clients for whom the division is requesting service.

B. Furnish copies of service/financial plans to the contractor.

C. Update eligibility/payment file to assure correct payment.

9. CONTRACTOR AND DIVISION MUTUALLY AGREE THAT:

A. If federal and/or state laws are amended, repealed or judicially interpreted so as to render fulfillment of this Agreement by either party not beneficial or impossible to perform, both Contractor and Division are discharged from further obligation created under terms of this Agreement, except for equitable settlement of possible overpayments or underpayments up to the date of the termination.

B. This Agreement shall remain in effect only as long as Contractor remains licensed and certified by the State Senior Services Division.

C. This Agreement may also be terminated either by mutual consent of the Division and the Contractor, or without cause, upon 30 days' written notice by either party.

D. If Contractor's certification is voluntarily or involuntarily terminated, the Division/Type B AAA agrees to assist all Title XIX clients in moving from the decertified beds, provided that the Contractor has secured prior consent from the clients and/or their guardian. In all cases, however, the Division will discontinue

payment for Contractor's services no later than 30 days subsequent to the termination of this Agreement.

E. If the Division has determined that a facility is deficient in areas relating to patient care or if the Division has made a determination of potential decertification (see Rule 416-17-090), *no* payment will be made under this Agreement by the Division for clients admitted to the facility after a date specified by the Division and until such time that the division determines that deficiencies have been corrected.

F. If Contractor does not correct deficiencies in accordance with Contractor's written plan of correction submitted to and approved by the Division, this Agreement may be terminated upon written notice.

G. Contractor shall upon written notice from Division take immediate steps to terminate any employe that in Division's judgement is a threat to the health, safety, or welfare of any client in Contractor's facility covered by this Agreement. Termination of facility employe'(s) shall be according to facility personnel policy and procedures.

H. Contractor must notify Division at least 30 days before sale or lease of the facility and provide the name of the buyer/lessee and names, addresses, and phone numbers of owners of the business entity buying or leasing the facility covered by this Agreement.

I. No payment to buyer or lessee of the facility will be made until buyer or lessee has received a new license, certification, and a contract from the Senior Services Division.

J. The conviction of the Contractor, or anyone having an ownership interest in the facility, of a criminal act involving Medicaid of Medicare laws, rules, or regulations will be grounds for termination of this Agreement by the Division.

K. Any breach or violation of any of the foregoing provisions shall make this Agreement subject to termination upon 30 days' written notice by the Division.

L. Division may recoup money paid to the contractor if the Division determines that services contracted for were not provided or were not provided in an acceptable manner. If recoupment is made, the amount recouped shall not be recovered in the year-end settlement.

M. Amounts due to or from the facility from an audit settlement are payable within 30 days of receipt of the audit report. Amounts not paid to the Division within 30 days will be recouped from the next monthly vendor payment, unless an extended payment plan is approved.

PART 4
ADDENDUM TO AGREEMENT FOR PARTICIPATION IN THE TITLE XIX HEAVY COST PROGRAM CONDITIONS

1. Definitions: Nursing facility, as used in this part, means a Skilled or Intermediate Care Facility, licensed and certified to provide care under Federal and State laws, rules and regulations under Title XVIII or Title XIX.

2. This addendum is the agreement for participation in the Title XIX Heavy Cost Program, between the State of Oregon acting through its Department of Human Resources, Senior Services Division, and the Nursing Facility, hereinafter referred to as contractor. Said contract is amended as follows:

   a. Division agrees to pay Contractor a special daily rate established by Division for the care of individuals identified by Division as eligible for "heavy cost" care. The client must occupy a bed certified by the State Senior Services Division and covered by an agreement with the Division. The "heavy cost" payment for an eligible client is in effect for a period specified by Division and extension will be reassessed as determined by Division. Contractor agrees to provide supplies and services included in the all-inclusive rate, as specified in the Title XIX Long-Term Care Facility Services Guide. In addition, Contractor will provide all exceptional nursing or personal services as required based on an assessment by the Division. The "heavy cost" rate does not include those medical services; i.e., physician, physical therapy, pharmacy, dental, etc., paid through Title XIX, Title XVIII, Veterans Administration, etc., and personal incidental items authorized for payment from the client's personal incidental allowance (see Rule 461-17-160). The heavy cost rate will be the rate established either for skilled (SNF) or intermediate (ICF) level of care.

   b. Contractor will maintain detailed, complete, and accurate records of the care provided and the costs of the

care. Records of services and costs will be made available to the Division upon request.

c. The modification, cancellation, or continuation of the arrangement set forth in this addendum will be the responsibility of Division to renegotiate with the Contractor.

[Legal sufficiency approval signatures omitted in printing]

APPENDIX B

Nuring Facility Contract

Part 1. Signators

This contract is between the State of Oregon, by and through the Department of Human Resources, Senior Services Division, hereinafter referred to as the "Division" in order to procure Nursing Facility services and

COOS BAY CARE CENTER
2625 Koos Bay Blvd.
Coos Bay, OR 97420

hereinafter referred to as "Contractor."

This ☐ SNF contract ☒ ICF contract ☐ extension ☒ Heavy Cost addendum ☐ Contiguous Area contract begins 01-01-87 and ends 10-31-87; however, it is not effective until signed by the Senior Services Division of the State of Oregon.

The following listed parts, together with attachments referred to therein and attached, form the whole of this contract.

Contract Documents

Place an X in the appropriate box(es).

- ☒ Part 1. Signators.
- ☒ Part 2. Skilled Nursing Facility and/or intermediate Care Facility Contract Conditions, paragraphs 1 through 9, pages 1 through 6 attached.
- ☐ Part 3. Extension of Nursing Facility Contract, paragraph 1 attached.
- ☒ Part 4. Heavy Cost Addendum, paragraphs 1 through 2 attached.
- ☐ Part 5. Area contiguous to Oregon, conditions, 1 page attached.

[Signatures and copy distribution omitted in printing]

PART 2
SKILLED/NURSING INTERMEDIATE CARE

1. Definitions: Nursing Facility, as used in this part, means a Skilled or Intermediate Care Facility, licensed and certified to provide care under Federal and State laws, rules and regulations under Title XVIII or Title XIX.

2. Pursuant to ORS 184-750, the Department of Human Resources, through Adult and Family Services Division (AFS), is the agency responsible for administering the Medical Assistance Program (Title XIX) in Oregon. By agreement, the Senior Services Division administers the Title XIX Long-Term Care Services Program.

3. Section 1902(a)(27) of Title XIX of the Social Security Act requires a state to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance. The purpose of this agreement is to assure that the facility is providing services appropriate to the needs of the clients in return for payment by the agency for services purchased and provided.

4. To participate in the Oregon Medical Assistance Program (Title XIX) a Nursing Facility must: (1) be licensed at the appropriate skill level as a nursing facility or hospital under the laws of Oregon; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing facility administrator who holds a current Oregon license or by a hospital administrator; and (4) be 100% Medicaid certified or as specified in OAR 411-70-010 and meet on a continuing basis federal standards for participation in the Title XIX Medical Assistance Program. All conditions apply to clients who are receiving assistance under Title XIX or the General Assistance Program.

5. Contractor has filed an application with the State Health Division to provide, as a Nursing Facility, health-related care and services to any and all persons eligible, and referred by SSD/AAA for the Title XIX Medical Assistance Program. The approved application is attached hereto and by this reference made a part of this Agreement.

CONTRACTOR AGREES TO:

A. Comply with all Oregon Administrative Rules and state statutes applicable to the operation of Nursing Facilities under the Title XIX Long-Term Care Facility Services Program.

B. Comply with all applicable sections of the Title XIX Social Security Act and amendments thereto and applicable regulations.

C. Inform Division/Type B Area Agency on Aging (AAA) in writing on the day of admittance or discharge when clients covered under the Title XIX Program are admitted to and discharged from the Nursing Facility.

D. Notify Division/Type B AAA on the first working day after transfer of the client to an acute care hospital and prior to therapeutic leave.

E. Notify Division/Type B AAA in writing on the date the license is changed or of any change in operating license issued by the State Health Division.

F. Meet the requirement of Residents' Bill of Rights as outlined in 42 CFR 442.311.

G. Provide cooperative methods and procedures relating to the utilization of care and services, as may be necessary to safeguard against unnecessary utilization of such care and services.

H. Submit annual cost statements within the established time limits and using the forms and instructions specified in the Title XIX Long-Term Care Facility Services Guide.

I. Submit billings for clients covered by this Agreement showing correct resident day counts, resident income, and payment rates consistent with dates and amounts, prior authorized by the Division/Type B AAA.

J. Contractor will maintain detailed, complete, and accurate records of the care provided and the costs of the care. Records of services and costs will be made avail-

able to the Division upon request, including information requested by telephone. The Division/Type B AAA has the right to photocopy any records, including incident reports and personnel records, deemed by the division necessary to carry out state and federal statutes and rules. The Contractor shall retain medical records for a minimum of seven years and financial records for a minimum of three years or from the date all audit questions have been resolved, whichever period is the longest. Records will include at least the following:

1) Records as required by Section 1905(c) and (d) of Title XIX of the Social Security Act and any amendments thereto;

2) Records of all treatments, drugs, and services for which Contractor has been or is to be paid under the Title XIX Program, including the authority for and the date of administration of such treatment, drugs, or services;

3) All other records as may be found necessary by Division in compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services, or by the Division, or as a result of a judicial action.

K. Provide access to residents as may be found necessary by Division/Type B AAA to comply with state and federal laws, rules, and regulations. This includes professional review organizations contracting with the Division.

L. Accept payment from the Division as payment in full for those services, goods, and products included in the all-inclusive per diem rate, with the understanding that: Whosoever knowingly and willfully: (1) charges for any such service, goods, or products in excess of the all-inclusive per diem rate established by the Division; or (2) charges, solicits, accepts or receives, in addition to the amount paid by the Division, any gift, money, donation, or other consideration as a pre-condition of admitting a client to a Nursing Facility, or as a require-

ment for the client's continued stay in such a facility, shall be guilty of a (federal) felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years or both.

M. Division may withhold payment because of violation of this Agreement by Contractor until the violation is remedied. If violations are not remedied in the time specified by Division in the violation notice, Division may terminate this Agreement upon 30 days' written notice.

N. Not to employ any person in a management or supervisory capacity who has been convicted of a criminal offense involving Medicaid or Medicare laws, rules, or regulations.

O. Assure that neither Contractor nor its employes shall aid, abet, or engage in any act detrimental to the health, safety, or welfare of the clients or in the abuse of clients under its care; nor shall Contractor hire or retain in employment persons whom it knows or should know were convicted for such practices.

P. Meet conditions for participation as a Nursing Facility required by Federal Regulations 42 CFR 442.101 and 442.300, and meet CFR 442.311 and 442.320 relating to patient rights and protection of patient funds.

Q. Notify the Division/Type B AAA of any client acquiring a change in level of nursing facility care, and cooperate with the division/AAA in making alternative plans with the client.

R. Comply with Title VI, Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

S. Comply with Executive Order 11246 entitled Equal Employment Opportunity as amended by Executive Order 11375 and as supplemented in Department of Labor Regulation 41 CFR Part 60. All subcontracts shall also comply with these provisions.

T. Maintain fiscal records and other records pertinent to this contract. All fiscal records shall be maintained

pursuant to accepted accounting standards and other records shall be maintained to the extent necessary to clearly reflect actions taken. Contractor further agrees to provide access to any books, documents, papers, and records of Contractor which are pertinent to this contract and, further, to allow the making of excerpts, transcripts, or performing audits or examinations thereof. Such access shall be freely allowed to state and federal personnel and their duly authorized agents.

All such records shall be retained and kept accessible for three years following final payment and conclusion of all pending matters. All subcontracts shall also comply with these provisions.

In addition, Contractor and its agents, employes, and subcontractors shall maintain all such records fully confidential. Such confidential status shall be in compliance with the requirements stated in 45 CFR 205.50 and 42 CFR 431 subpart F.

U. Abide by all mandatory standards and policies which relate to energy effeciency and which are contained in the State of Oregon energy conservation plan which was issued in compliance with the Energy Policy and Conservation Act (PL 94-165). All subcontracts shall also be in compliance with the foregoing.

V. Ensure that if the sum payable under this contract exceeds or may exceed $100,000, the Contractor shall provide the State of Oregon a written assurance the Contractor will comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act ($2 [*sic*] USC 1857 H) Section 508 of the Clean Water Act (33 USC 1368) Executive Order 11738 and Environmental Protection Agency regulation (40 CFR Part 15), and further, Contractor agrees to promptly report all infractions to the State of Oregon, the Federal Grantor Agency, and to the U.S. Environmental Protection Agency. All subcontracts shall also be in compliance with these provisions.

7. DIVISION AGREES TO:

A. Make payments to Contractor in accordance with all Oregon Administrative Rules applicable to Nursing

Facilities under the Title XIX Long-Term Care Facility Services Program, as soon as feasible after a proper claim is submitted and approved.

B. Give Contractor reasonable notice in writing of any change related to the Division Title XIX Medical Assistance Program that will affect Contractor.

8. DIVISION/TYPE B AAA AGREES TO:

A. Prior authorize payments for clients for whom the division is requesting service.

B. Furnish copies of service/financial plans to the contractor.

C. Update eligibility/payment file to assure correct payment.

9. CONTRACTOR AND DIVISION MUTUALLY AGREE THAT:

A. If federal and/or state laws are amended, repealed or judicially interpreted so as to render fulfillment of this Agreement by either party not beneficial or impossible to perform, both Contractor and Division are discharged from further obligation created under terms of this Agreement, except for equitable settlement of possible overpayments or underpayments up to the date of the termination.

B. This Agreement shall remain in effect only as long as Contractor remains licensed and certified by the State Health Division.

C. This Agreement may also be terminated either by mutual consent of the Division and the Contractor, or without cause, upon 30 days' written notice by either party.

D. If Contractor's certification is voluntarily or involuntarily terminated, the Division/Type B AAA agrees to assist all Title XIX clients in moving from the decertified beds, provided that the Contractor has secured prior consent from the clients and/or their guard-

ian. In all cases, however, the Division will discontinue payment for Contractor's services no later than 30 days subsequent to the termination of this Agreement.

E. If the Division or the State Health Division has determined that a facility is deficient in areas relating to patient care or if the Health Division has made a determination of potential decertification (see Rule 416-17-090), *no* payment will be made under this Agreement by the Division for clients admitted to the facility after a date specified by the Division and until such time that the division determines that deficiencies have been corrected.

F. If Contractor does not correct deficiencies in accordance with Contractor's written plan of correction submitted to and approved by the Division or Health Division, this Agreement may be terminated upon written notice.

G. Contractor shall upon written notice from Division take immediate steps to terminate any employe that in Division's judgement is a threat to the health, safety, or welfare of any client in Contractor's facility covered by this Agreement. Termination of facility employe'(s) shall be according to facility personnel policy and procedures.

H. Contractor must notify Division at least 30 days before sale or lease of the facility and provide the name of the buyer/lessee and names, addresses, and phone numbers of owners of the business entity buying or leasing the facility covered by this Agreement.

I. No payment to buyer or lessee of the facility will be made until buyer or lessee has received a new license and certification from the Health Division, and a contract from the Senior Services Division.

J. The conviction of the Contractor, or anyone having an ownership interest in the facility, of a criminal act involving Medicaid of Medicare laws, rules, or regulations will be grounds for termination of this Agreement by the Division.

K. Any breach or violation of any of the foregoing provisions shall make this Agreement subject to termination upon 30 days' written notice by the Division.

L. Division may recoup money paid to the contractor if the Division determines that services contracted for were not provided or were not provided in an acceptable manner. If recoupment is made, the amount recouped shall not be recovered in the year-end settlement.

M. Amounts due to or from the facility from an audit settlement are payable within 30 days of receipt of the audit report. Amounts not paid to the Division within 30 days will be recouped from the next monthly vendor payment, unless an extended payment plan is approved.

PART 4

ADDENDUM TO AGREEMENT FOR PARTICIPATION IN THE TITLE XIX HEAVY COST PROGRAM CONDITIONS

1. Definitions: Nursing facility, as used in this part, means a Skilled or Intermediate Care Facility, licensed and certified to provide care under Federal and State laws, rules and regulations under Title XVIII or Title XIX.

2. This addendum is the agreement for participation in the Title XIX Heavy Cost Program, between the State of Oregon acting through its Department of Human Resources, Senior Services Division, and the Nursing Facility, hereinafter referred to as contractor. Said contract is amended as follows:

   a. Division agrees to pay Contractor a special daily rate established by Division for the care of individuals identified by Division as eligible for "heavy cost" care. The client must occupy a bed certified by the State Health Division and covered by an agreement with the Division. The "heavy cost" payment for an eligible client is in effect for a period specified by Division and extension will be reassessed as determined by Division. Contractor agrees to provide supplies and services included in the all-inclusive rate, as specified in the Title XIX Long-Term Care Facility Services Guide. In addition, Contractor will provide all exceptional nursing or personal services as required based on an assessment by the Division. The "heavy cost" rate does not include those medical services; i.e., physician, physical therapy, pharmacy, dental, etc., paid through Title XIX, Title XVIII, Veterans Administration, etc., and personal incidental items authorized for payment from the client's personal incidental allowance (see Rule 461-17-160). The heavy cost rate will be the rate established either for skilled (SNF) or intermediate (ICF) level of care.

   b. Contractor will maintain detailed, complete, and accurate records of the care provided and the costs of the

care. Records of services and costs will be made available to the Division upon request.

c. The modification, cancellation, or continuation of the arrangement set forth in this addendum will be the responsibility of Division to renegotiate with the Contractor.

[Legal sufficiency approval signatures omitted in printing]

FILED
SEP 25 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,
Petitioners,

v.

COOS BAY CARE CENTER, INC., an Oregon Corporation; HANNAH SCHWANKE, Guardian *Ad Litem* for David and Steven Gibbs; and SANDI WATSON-STOWELL, Guardian *Ad Litem* for Tami Watson,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' SUPPLEMENTAL BRIEF AND REPLY IN SUPPORT OF MOTION TO DISMISS

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RULE 28.1 LIST

Respondent Coos Bay Care Center, Inc. has no parent company, subsidiaries or corporate affiliates to list pursuant to Rule 28.1.

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On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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RESPONDENTS' SUPPLEMENTAL BRIEF AND REPLY IN SUPPORT OF MOTION TO DISMISS[1]

STATEMENT OF THE CASE

The statement of the case and the relevant facts are set forth in Respondent's Motion to Dismiss.

Respondents Coos Bay Care Center, Inc. (Coos Bay) and Hannah Schwanke file this supplemental brief to reply to petitioners' arguments in opposition to the motion to dismiss

[1] This supplemental brief is filed on behalf of both respondent Coos Bay Care Center, Inc. and respondent Hannah Schwanke as guardian *ad litem* for David and Stevens Gibbs. Respondent Hannah Schwanke joins in the Motion to Dismiss.

and to apprise the Court of a recent development which affects this case. Effective on or about July 1, 1987, Oregon repealed and replaced the statute governing payment for nursing home services. The new statute directs petitioner Oregon Department of Human Resources, Senior Services Division to establish rules implementing a "patient-based reimbursement system." S. Bill 517, § 2.[2]

ARGUMENT

I. THE ENACTMENT OF OREGON SENATE BILL 517 MAY MOOT THIS CASE BY REPLACING THE EXISTING MEDICAID REIMBURSEMENT SYSTEM WITH A NEW REIMBURSEMENT SYSTEM.

Senate Bill 517 requires implementation of a "patient-based reimbursement" system for nursing home services, defined as "reimbursement for direct patient care according to the needs of the patient, based on multiple levels of patient health, functioning and impairment." S. Bill 517, § 2(1) and (2). The statute mandates that the reimbursement system "meet the legitimate costs of caring for patients." *Id.* at § 2(1). The statute was effective on or about July 1, 1987 and petitioner Oregon Department of Human Resources, Senior Services Division was directed to promulgate rules establishing both "definitions of levels of care and the payment rates for the patient-based reimbursement system." *Id.* at § 2(3).

Implementation of patient-based reimbursement criteria will fundamentally alter the reimbursement system challenged in the Complaint. This action was filed because petitioners set

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[2] Because of the lag time in publishing state session laws, counsel for respondents only discovered the existence of Senate Bill 517 after the Motion to Dismiss had been printed. Counsel informed counsel for petitioners about the existence of the new law in a telephone conversation which preceded the filing of petitioners' Response in Opposition to Motion to Dismiss ("Pet. Resp."). (A copy of the law, referred to here as "Senate Bill 517," is included as the appendix to this brief.)

nursing home reimbursement rates without considering patient needs, thereby depriving the patient respondents [3] of the quantity and quality of care guaranteed them by federal and state law. J.A. at 6. The new statute expressly addresses this issue, ordering petitioners to "meet the legitimate costs of caring for patients" by predicating reimbursement on the "needs of the patient, based on multiple levels of patient health, functioning and impairment." S. Bill 517, § 2.

Although the new statute is similiar in many respects to its predecessor, there are significant distinctions. The most obvious distinction is a clause which requires the Senior Services Division to establish rules defining levels of care and payment rates for the new patient-based reimbursement system. The formal directive to establish rules implementing the new reimbursement methodology apparently was added because petitioners ignored the statute's predecessor and failed to implement the patient-based reimbursement system required by the now-repealed legislation.

A change in the statutory scheme may moot a challenge to that statutory scheme, requiring dismissal. *See, e.g., Green v. Mansour*, 474 U.S. 64 (1985). In this case, the change in the law goes to the heart of the conflict and, unless disregarded by petitioners, may moot the substantive issues raised by the Complaint.

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[3] As correctly noted by petitioners, the individual plaintiffs are guardians *ad litem* for patients of the facility. *See* Pet. Resp. at 1, n.1. For ease of reference, this brief will also refer to the "plaintiff" or "respondent patients."

II. DESPITE PETITIONERS' ARGUMENTS TO THE CONTRARY, THE SALE OF THE ASSETS OF THE COOS BAY CARE CENTER TO THE SOUTHMARK CORPORATION RENDERS THIS CASE MOOT, REQUIRING DISMISSAL.

A. The Eleventh Amendment In Combination With The Sale Of The Nursing Home Requires Dismissal Of This Case.

Petitioners' erroneously argue that respondents' claims for retrospective relief remain viable, preventing the controversy from being mooted. Pet. Resp. at 6-8.[4] Petitioners argue that "[m]ootness simply is the wrong analytic label" and that Coos Bay has confused the issue of entitlement to relief with the "existence of a legally cognizable controversy." *See* Pet. Resp. at 7.[5]

This Court, however, has held that Article III of the Constitution precludes jurisdiction if the plaintiff's injury cannot be redressed by a favorable decision. *See, e.g., Valley Forge College v. Americans United for Separation of Church and State*, 454 U.S. 464, 472 (1982). Similarly, this Court has held that the applicability of the Eleventh Amendment jurisdictional bar depends entirely on whether prospective relief will redress plaintiff's injury, and not upon whether a legal controversy

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[4] Petitioners characterize the Motion to Dismiss as a "transparent attempt to call off an ongoing battle because, from the respondent's perspective, it is going badly." Pet. Resp. at 3. Petitioners ignore counsels' obligation, made explicit by this Court, to "'inform the Court of any development which may conceivably affect the outcome of the litigation.'" *Board of License Comm'rs of the Town of Tiverton v. Pastore*, 469 U.S. 238, 240 (1985) (*per curiam*) (quoting *Fusari v. Steinberg*, 419 U.S. 379, 391 (1975) (Burger, C.J., concurring)). Petitioners' characterization also is presumptuous, particularly in light of this Court's longstanding rulings on the issues raised by this case. *See, e.g., Rosado v. Wyman*, 397 U.S. 397, 406 (1970); *Carter v. Stanton*, 405 U.S. 669, 671 (1972). *See Maine v. Thiboutot*, 448 U.S. 1 (1980).

[5] Petitioners have not waived their Eleventh Amendment immunity. Indeed, it is clear that counsel for petitioners cannot waive the immunity defense, rather, that waiver must come from the State itself. *See generally Florida Dep't of State v. Treasure Salvors, Inc.*, 458 U.S. 670, 683 n.18 (1982).

continues to exist between the parties. *See, e.g., Quern v. Jordan,* 440 U.S. 332, 337 (1979); *Green v. Mansour,* 474 U.S. 64 (1985).

In *Florida Department of Health and Rehabilitative Services v. Florida Nursing Home Association,* 450 U.S. 147 (1981) (*per curiam*), for example, this Court ordered dismissal of a case seeking increased Medicaid payments because amendments to both the federal and state Medicaid statutes mooted the claims for prospective relief. While the nursing home's claims for retrospective relief remained "viable" in the same sense that respondents' claims for retrospective relief here remain viable, this Court held that in the absence of viable claims for prospective relief, the Eleventh Amendment required dismissal. *Id. See also* Respondent's Motion to Dismiss at 7-9. Thus, as here, where a change in the factual circumstances or a change in the challenged law moots all claims for prospective relief, the Eleventh Amendment deprives the federal courts of jurisdiction and the case must be dismissed.

B. The Sale Of The Nursing Home And The Adoption Of A Patient-Based Reimbursement System Moots The Claims For Prospective Relief As To All Respondents.

1. Coos Bay's Claims.

Petitioners acknowledge that Coos Bay's claims for prospective relief have been mooted by the sale of the nursing home's assets to a new corporate owner, the Southmark Corporation.[6] Petitioners nonetheless argue that "Southmark has simply stepped into CBCC's shoes" (Pet. Resp. at 10) and should be compelled to become a plaintiff pursuant to Federal Rule of Civil Procedure 25(c).[7] The argument is wrong.

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[6] Petitioners state: "On the question of injunctive and declaratory relief, CBCC[,] Inc. correctly points out that the sale of the care facility terminated any prospective interest it had in future Medicaid reimbursement levels." *See* Pet. Resp. at 8.

[7] Rule 25(c), of course, governs the district courts. Supreme Court Rule 40 provides for substitution of parties before this Court in certain circumstances, none of which are asserted by petitioners. Respondents address

(footnote continues)

Rule 25(c) provides that "[i]n case of any transfer of interest" the court upon motion may direct the person to whom the interest is transferred to be substituted in the action or joined with the original party. Two principles applicable to this matter are derived from the rule. First, the rule requires, as a prerequisite to substitution, transfer of an interest in the subject of the litigation. Second, Rule 25(c) "does not determine what actions shall survive the . . . transfer of interest by a party; it deals only with the mechanics of substitution in an action which *does* survive under the applicable substantive law." 3B J. Moore and J. Kennedy, Moore's Federal Practice ¶ 25.04[3] (2d ed. 1987).

The mere sale of assets by a litigant to an unrelated party for use in that party's independent business ventures generally is not a basis to force the purchaser to become an unwilling plaintiff. *Cf. Golden State Bottling v. NLRB*, 414 U.S. 168 (1973); *R.J. Engstrom Corp. v. Interceptor Corp.*, 555 F.2d 277 (10th Cir. 1977). Moreover, there was no transfer of interest in the litigation from Coos Bay to Southmark.

Coos Bay could not transfer its provider agreement, *i.e.*, its entitlement to Medicaid reimbursement, to Southmark. The federal regulation relied upon by petitioners establishes that Southmark's claim to Medicaid reimbursement arises solely because the Medicaid agency, *i.e.*, petitioners, assigned the provider agreement to Southmark. *See* 42 C.F.R. § 442.16. The assignment occurred only because Southmark applied to petitioners for relicensure and recertification. *See* Motion to Dismiss, App. B at 12a. Relicensure and recertification—which petitioners concede is "one of the most important

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(footnote continued)

petitioners' arguments in the interest of expediency. However, it should be noted that none of the facts on which petitioners rely are part of the record and the request denies Southmark the opportunity to be heard. Further, even petitioners concede the futility of their effort to keep this case alive, stating that "[i]t may be that if this case were returned to the district court for trial, neither CBCC Inc. nor Southmark would choose to devote their resources to pursuing their claims." Pet. Resp. at 10. Petitioners' statement highlights the abstractness of review by this Court and raises a substantial question whether there remains any case of controversy which ought to be adjudicated by the federal courts.

Medicaid procedural hurdles to clear" (Pet. Resp. at 10)— was required precisely because Southmark did not "step into CBCC's shoes." Southmark was required to establish its own claim to payment and to assume independently the obligations imposed on nursing home owners by state and federal law.

There are other indications that Southmark is neither a continuation of Coos Bay, Inc. or the *de facto* or *de jure* successor in interest to the claims asserted by Coos Bay. Southmark is entirely unrelated to Coos Bay. Southmark acquired the nursing home in a multi-million dollar transaction involving twenty-eight nursing homes. The purchase and sale were negotiated at arm's length. No one who held an ownership interest in the Coos Bay Care Center is related in any way to Southmark. Southmark purchased only designated assets from respondent Coos Bay, specifically excluding any claim against petitioners. Respondent Coos Bay, Inc. continues to exist and retains all of its claims against the Oregon Medicaid program. *See generally* Motion to Dismiss, App. A at 7a-8a.

Further, despite petitioners' claim that "[n]one of the relevant facts has [sic] changed" (Pet. Resp. at 10), Southmark's factual position is quite different from that of respondent Coos Bay. In July 1987, for example, Southmark received an across-the-board Medicaid rate increase of approximately five dollars per patient, per day.[8] The rate increase reflects the fact that Southmark's costs of delivering care—the basis for Medicaid reimbursement—are not identical to those experienced by the former operator, respondent Coos Bay. Thus, a judgment that Coos Bay is entitled to greater Medicaid reimbursement than paid by petitioners does not compel a finding that Southmark also has been under-reimbursed. Finally, the new Oregon statute, S. Bill 517, orders the Senior Services Division, one of the petitioners here, to "establish by rule definitions of levels of care and the payment rates for [a] patient-based reimbursement system" which reimburses "direct patient care according to the needs of the patient" and "meet[s] the legitimate costs of caring for patients." S. Bill 517, § 2. Due to

[8] According to Southmark officials, the "all-inclusive" intermediate care rate increased from $42.61 to $47.60 per patient, per day. The "heavy cost" rate increased from $51.54 to $56.25 per patient, per day.

the increased payments, the change in the cost of delivering care and the change in the statutory reimbursement criteria, officials of Southmark have advised counsel that, in their view, litigation against the Oregon Medicaid Program is not warranted at this time.[9]

Petitioners' relicensure and recertification of the nursing home belie the claim that the purchase and sale were without legal significance. Any injury which Southmark might suffer because of petitioner's illegal conduct—and none is alleged in this record—is entirely a result of Southmark's relationship with petitioners and did not result from the transfer of any interest by Coos Bay. Finally, Southmark, which recently received a rate increase of five dollars per patient, per day, operates the nursing home in a different economic and legal environment than did Coos Bay. No claim Southmark might have against petitioners is presently before the Court. There is no basis to substitute Southmark as a plaintiff in this litigation.[10]

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[9] Such officials have indicated their intent to pursue any reimbursement disputes with State officials informally.

[10] *DeVeau v. Braisted*, 363 U.S. 144, 146 n.2 (1960), cited by petitioners is inapposite. In that case, the plaintiff/appellant was an individual, not the union, and the fact that the original union of which plaintiff was an officer was disbanded was only marginally relevant to the controversy. In *NLRB v. Insurance Agents*, 361 U.S. 477, 500 n.32 (1960), also cited by petitioners, the mootness issue was not raised. In that case, the original defendant union had *merged* with a second union. A merger of two entities clearly has distinct implications from a purchase of assets—the type of transaction at issue here. *See* Motion to Dismiss at 3-5. Southmark and respondent Coos Bay Care Center Inc. remain two distinct corporate entities, unrelated by ownership or control.

Petitioners repeatedly cite cases which stand for the proposition that mere voluntary cessation of a challenged practice does not moot a case and that if the challenged actions are capable of repetition yet evading review, the case is not moot. *See* Pet. Resp. at 7, *citing City of Mesquite v. Alladin's Castle, Inc.*, 455 U.S. 283 (1982); *id.* at 11, *citing Carrol v. President and Comm'rs of Princess Anne*, 393 U.S. 175 (1968). These cases are also inapposite. This case parallels *Board of License Comm'rs of the Town of Tiverton v. Pastore*, 469 U.S. 238 (1985). There is no suggestion that any future controversy between the parties is of such short duration that it is capable of repetition, yet evading review.

2. The "Patient Plaintiffs" And The Putative Class.

Petitioners concede that "Tami Watson's interests in prospective relief may now be moot, given her classification as a heavy cost patient".[11] Pet. Resp. at 12-13. Because the cost of Tami Watson's care is paid at the heavy cost rate, she suffers no continuing injury and asserts no claim within the jurisdiction of the federal courts. *See, e.g., Edelman v. Jordan*, 415 U.S. 651, 668 (1974). *See also* Pet. Brief on the Merits at 41.[12]

Petitioners erroneously argue that the sale of the nursing home has no impact on the status of the remaining plaintiffs because "[a]t most, David and Steven Gibbs would have to amend the complaint to refer to the new corporate owner where relevant references to CBCC Inc. previously appeared." Pet. Resp. at 12. The argument ignores the nature of the injury alleged in the Complaint.

The Complaint alleges that petitioners have deprived respondents of rights conferred by the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, but the injury in fact necessary to confer standing, as contrasted with the abstract violation of a federal statute, is the actual deprivation of necessary care and treatment. The injury in fact alleged by the patient plaintiffs, as petitioners appear to recognize, is the allegation that "David and Steven Schwanke [sic] and Tami Mauer [sic], and the class they represent do not receive the quantity or quality of care guaranteed to them" by federal and state law "although Plaintiff Coos Bay Care Center does afford 'heavy care' patients as much 'heavy care' as possible." Complaint, J.A. at 6. *See also* Pet. Resp. at 12.

There is no allegation before the Court—only petitioners' abstract speculation—that Southmark, the new owner of the nursing home, has failed to provide appropriate care or that the patients are receiving deficient care from the new owner. It makes little jurisdictional difference that the patient respondents may have alleged insufficient care when the nursing home

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[11] As the Court previously was advised, counsel does not represent Ms. Watson or her guardian. The status of Ms. Watson's representation remains unclear.

[12] Petitioners stated: "Clearly, however, the claim for retroactive monetary damages is barred by the Eleventh Amendment." Pet. Brief at 41.

was operated by respondent Coos Bay. Unless the patients continue to be deprived of guaranteed care, they suffer no injury in fact, have no standing and this case is moot.

The ability of the present owner, Southmark, to deliver appropriate care, and whether such care actually has been delivered, are unrelated to the ability of Coos Bay to deliver such care. The ability of a nursing home operator to deliver appropriate care within available reimbursement levels is a function of numerous variables ranging from patient mix to staffing and including the intangible skills and resources which permit one nursing home to deliver care more economically and efficiently than another. Thus, the costs of delivering mandated levels of nursing care differ greatly from nursing home to nursing home.[13]

Whether the patients might be able to allege a continuing injury in fact based on the quantity or quality of care provided to them by Southmark is not revealed by the record before the Court. Plainly, however, the injury in fact alleged by the named plaintiffs in the complaint—predicated on respondent Coos Bay's inability to deliver care—is no longer on-going because Coos Bay no longer provides care of any type, and thus the claims presently before the Court have become moot.

Further, the new Oregon statute formally directs the Senior Services Division to establish rules defining levels of care and payment rates for patient-based reimbursement. The statute appears to require consideration of many of the factors which caused the injury alleged here. Unless petitioners ignore the command of the legislature, the new statute will result in implementation of a new reimbursement methodology distinct from that at issue here, an event which will moot all of the patient plaintiffs claims, including the putative class members claims.

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[13] Any claim that the new owner, Southmark, provides deficient care due to under-reimbursement by petitioners raises factual issues distinct from those made out here by respondents and is properly the subject of a separate lawsuit if anyone chooses to bring such a case. If brought, the lawsuit will focus on the ability of Southmark, with its unique capital structure and operating costs—not Coos Bay—to deliver appropriate care. Undoubtedly one of the significant issues raised in any such litigation will be the impact of the across-the-board rate increase of approximately five dollars per patient, per day received by Southmark after acquiring the nursing home.

Petitioners erroneously argue that the case is not moot as to the putative class even if the claims of the named patient plaintiffs are moot. This Court has held that a case is moot and must be dismissed if the claims of the class representatives are moot, unless a class has been certified by the lower courts pursuant to Federal Rule of Civil Procedure 23. *See Board of School Comm'rs v. Jacobs*, 420 U.S. 128, 129 (1975); *see also Kremens v. Bartley*, 431 U.S. 119, 129-130 (1977).

CONCLUSION

For the reasons stated herein and in the Motion to Dismiss, this case must be dismissed.

Respectfully submitted,

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APPENDIX

64th OREGON LEGISLATIVE ASSEMBLY—1987
Regular Session

B-Engrossed
Senate Bill 517

Ordered by the Senate June 8
Including Senate Amendments dated April 27
and June 8

Sponsored by Senators ROBERTS, OLSON (at the request of United Seniors, Oregon Health Care Association, Oregon Association of Homes for the Aging)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

[*Establishes*] Directs Senior Services Division to develop by rule patient-based reimbursement system with quality incentive payments for nursing facilities. Defines patient-based reimbursement [*and quality incentive payment. Creates Quality Incentive Fund*].

[*Appropriates $ for biennium.*]

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to nursing facility reimbursement; creating new provisions; repealing ORS 410.850; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 410.850 is repealed and section 2 of this Act is enacted in lieu thereof.

SECTION 2. (1) The Legislative Assembly finds and declares that patients admitted to and cared for by long term care facilities in Oregon are more impaired than in the past. In keeping with the traditional commitment of the State of Oregon to the care and protection of its frail, elderly and handicapped citizens, as expressed in ORS 410.020(1) to (6), the Legislative Assembly declares that a patient-based reimbursement system emphasizing quality incentives is appropriate for long term care facilities. Such a system would reward long term care facilities for outcomes, such as maintaining or improving a patient's condition, and meet the legitimate costs of caring for patients.

(2) "Patient-based reimbursement" means reimbursement for direct patient care according to the needs of the patient, based on multiple levels of patient health, functioning and impairment. Notwithstanding the above, patient-based reimbursement does not require the Senior Services Division to assess each patient and reimburse long term care facilities according to the constantly changing conditions of the patients except for changes between skilled and intermediate levels of care which shall result in prompt readjustment of rates.

(3) The Senior Services Division shall establish by rule definitions of levels of care and the payment rates for the patient-based reimbursement system.

SECTION 3. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1987.

NOTE: Matter in bold face in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

COUNSELS' NOTE: A copy of this bill was provided to respondents' counsel by the Oregon Legislative Reference Service who represented that the bill had been signed into law.

No. 86-1419

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, INC., an Oregon Corporation;
HANNAH SCHWANKE, Guardian Ad Litem for
David and Steven Gibbs; and SANDI
WATSON-STOWELL, Guardian Ad Litem for Tami Watson

Respondents.

On Writ Of Certiorari To The United States
Court of Appeals For The Ninth Circuit

AFFIDAVIT OF SERVICE OF RESPONDENTS' SUPPLEMENTAL BRIEF AND REPLY IN SUPPORT OF MOTION TO DISMISS AND NOTICE OF APPEARANCE

Janice L. Hoffman, being duly sworn, deposes and says:

I am a member in good standing of the Bar of the District of Columbia Court of Appeals. On this 25th day of September 1987, I instructed Ms. Beverly A. Patton, my secretary, to serve via

United States mail, first class, postage prepaid, three true and correct copies of Respondents' Supplemental Brief and Reply In Support of Motion to Dismiss and Notice of Appearance on each of the following counsel of record for the parties and amicus:

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Ms. Patton subsequently reported to me that she had deposited the envelopes containing the service copies in a mailbox in front of the United States Post Office located at 1111 - 20th Street, N.W., Washington, D. C. 20036 at 12:55 p.m. on that day.

I further attest that all parties required to be served have been served.

Respectfully submitted,

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of)
Columbia)

Subscribed to and sworn before me this 25th day of September, 1987.

Beverly A Patton
Notary Public

My Commission Expires: 4/30/91

bap:371-06cs

Supreme Court, U.S.
FILED
JUL 24 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1419

In the Supreme Court of the United States

OCTOBER TERM, 1987

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES, ET AL., PETITIONERS

v.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Section 1902(a)(13)(A) of the Social Security Act, 42 U.S.C. (& Supp. III) 1396a(a)(13)(A), requires States that elect to participate in the Medicaid program to submit to the Secretary of Health and Human Services, and have approved, a plan for medical assistance that "provide[s] for payment * * * of the hospital, skilled nursing facility, and intermediate care facility services * * * through the use of rates (determined in accordance with methods and standards developed by the State * * *) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate * * *." The question presented is whether a health care provider and individual patients may bring an action under 42 U.S.C. 1983 to challenge a State's failure to make certain Medicaid payments, in purported violation of 42 U.S.C. (& Supp. III) 1396a(a)(13)(A).

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Cannon v. *University of Chicago*, 441 U.S. 677 (1979)	14, 16, 22
Dugan v. *Rank*, 372 U.S. 609 (1963)	7
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Edwards v. *District of Columbia*, No. 85-6150 (D.C. Cir. June 12, 1987)	14, 15, 16, 17
Franchise Tax Board v. *Construction Laborers Vacation Trust*, 463 U.S. 1 (1983)	9
Gully v. *First Nat'l Bank*, 299 U.S. 109 (1936)	9
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Cases—Continued: Page

Merrell Dow Pharmaceuticals Inc. v. *Thompson*, No. 85-619 (July 7, 1986) 9, 10
Middlesex County Sewerage Auth. v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1 (1981) 8, 11, 13
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42 U.S.C. 1396b(a)(7) 2
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Brown, *Pennhurst As A Source of Defenses For State And Local Governments*, 31 Cath. U.L. Rev. 449 (1982) 14
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48 Fed. Reg. (1983):
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H. Conf. Rep. 96-1479, 96th Cong., 2d Sess. (1980) 20
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Health Care Financing Admin., Dep't of Health and Human Services, *Medicaid Financial Management Report: Fiscal Year 1986* 2

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S. Rep. 96-471, 96th Cong., 1st Sess. (1979) 18, 19, 20

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1419

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES, ET AL., PETITIONERS

v.

COOS BAY CARE CENTER, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

Medicaid is a cooperative federal-state program "providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons" (*Harris* v. *McRae*, 448 U.S. 297, 301 (1980)). In developing plans for administering the Medicaid program, States are given considerable discretion in determining who will receive Medicaid assistance and what kinds of assistance will be provided. State Medicaid plans, however, must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. 42 U.S.C. (& Supp. III) 1396a.

The court of appeals has held that a health care provider and certain individual patients may bring an action under 42 U.S.C. 1983 to challenge a State's alleged failure to provide sufficient Medicaid reimbursement, in purported violation of 42 U.S.C. (& Supp. III) 1396a(a)(13)(A). The United States has a significant financial stake in the disposition of that issue. By law, the federal government

provides between 50% and 83% of the cost of patient care, as determined by a formula keyed to per capita income. See 42 U.S.C. (& Supp. III) 1396d(b). In fiscal year 1986 alone, the federal contribution to the Medicaid program for medical assistance totalled $23.4 billion, making Medicaid one of the largest items in the federal budget.[1] Beyond this, the federal government makes at least a 50% contribution to the States' administrative expenses under the Medicaid program—including the cost of defending actions, like this one, for purported violations of the Social Security Act. See 42 U.S.C. 1396b(a)(7). In fiscal year 1986, the United States covered approximately $1.25 billion of state administrative costs.[2]

The United States also has a substantial interest in the particular legal question presented here. The Medicaid statute requires States to establish administrative procedures that afford providers and recipients an opportunity to challenge reimbursement decisions. See 42 U.S.C. 1396a(a)(3) and (37)(B); 42 C.F.R. 447.253(c), 431.220 *et seq.* Under the court of appeals' decision, however, persons may bypass state administrative procedures entirely, in favor of a federal-court action under Section 1983. That result, if upheld by this Court, would have a significant impact on the Medicaid program. It would enable thousands of routine cases like the present one—involving a claim that the State failed to make adequate reimbursement to a health care provider and its patients—to be brought in federal court. Such an explosion of litigation would vastly increase the cost of the Medicaid program,

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[1] Health Care Financing Admin., Dep't of Health and Human Services, *Medicaid Financial Management Report: Fiscal Year 1986* [hereinafter *Medicaid Financial Management Report*]. Of this sum, HHS provided $170.6 million to the State of Oregon.

[2] *Medicaid Financial Management Report*. Of this amount, some $20.3 million was provided to Oregon.

to the detriment of both the state and federal governments, and to the ultimate detriment of Medicaid recipients.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera*, No. 85-632 (June 23, 1986), slip op. 2; *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). As a cooperative federal-state program, Medicaid leaves the decision whether to participate to the sole discretion of each State. Once that initial decision has been made, States electing to participate must comply with basic requirements imposed by the Act and by the Secretary of Health and Human Services (see 42 U.S.C. (& Supp. III) 1396a; *Rivera*, slip op. 2; *Gray Panthers*, 453 U.S. at 37). Within those basic limits, however, each State has great flexibility both in administering its program and in deciding what specific provisions its program will contain.

In order to qualify for federal assistance, participating States must submit to the Secretary, and have approved, "a plan for medical assistance" (42 U.S.C. (& Supp. III) 1396a(a)). Amongs other things, such a plan must provide (42 U.S.C. (& Supp. III) 1396a(a)(13)(A)):

> for payment * * * of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State * * *) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically

> operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access * * * to inpatient hospital services of adequate quality.

In addition, a state plan must provide "an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance * * * is denied or is not acted upon with reasonable promptness" (42 U.S.C. 1396a(a)(3)). The plan must also "provide for procedures of prepayment and postpayment claims review, including review of appropriate data * * * to ensure the proper and efficient payment of claims and management of the program" (42 U.S.C. 1396a(a)(37)(B)).[3]

2. The State of Oregon has elected to participate in the Medicaid program and has submitted to the Secretary, and had approved, a plan for medical assistance pursuant to 42 U.S.C. (& Supp. III) 1396a(a). As part of its plan, Oregon has established administrative rules that specify maximum per diem rates of reimbursement for skilled nursing and intermediate care facilities. See Pet. App. 41-43. Oregon has also established a so-called Heavy Cost Program (*id.* at 39), under which the State provides an "add-on to the facility's established rate for the client's level of care." The "heavy cost" add-on, which includes complete reimbursement for nursing staff services, food, dressings, catheters and other supplies, is made available for "functional

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[3] The Secretary's regulations under 42 U.S.C. (& Supp. III) 1396a(a)(13) elaborate on these required state review procedures, mandating that the States have an "appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the [state] agency determines appropriate, of payment rates." 42 C.F.R. 447.253(c). See also 42 C.F.R. 431.220(a), 431.241, 431.246.

quadriplegi[cs] * * * [who are] ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital" (*ibid.*).

Respondents are Coos Bay Care Center, an intermediate care facility, and the guardians ad litem of three patients residing at Coos Bay. On April 27, 1984, respondents brought this class action under 42 U.S.C. 1983 to challenge Oregon's reimbursement practices for heavy-cost patients (Pet. App. 31-38). Respondents alleged that there are "a number of patients at the Coos Bay Center, and at other similar institutions within the State of Oregon, who are eligible for heavy cost care." Respondents further alleged that Oregon officials, "acting under color of state law, have developed an unconstitutional de facto policy procedure, custom and usage of consistently and repeatedly refusing to pay the cost of the heavy care patients." *Id.* at 34-35. Respondents alleged violations of the Fourteenth Amendment and of 42 U.S.C. 1396a and 1983. Respondents prayed for $138,600 in damages for Coos Bay Center, $10,000 in damages for each class member, declaratory and injunctive relief, and attorney's fees (Pet. App. 35, 37-38).

3. The district court, adopting the recommendation of a magistrate (Pet. App. 7-8), dismissed the complaint with prejudice. The magistrate concluded that the Medicaid Act "created no substantive rights" and that respondents were therefore "precluded from attempting to 'enforce' [the Act] by way of 42 U.S.C. § 1983" (Pet. App. 14).[4]

The court of appeals reversed (Pet. App. 1-5). It first held that respondents had sufficiently pleaded a violation of the Social Security Act by alleging that Oregon had

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[4] The magistrate also held that there is no private right of action under 42 U.S.C. 1396(a) and dismissed for want of federal jurisdiction respondents' state law claim for breach of contract (Pet. App. 12-13, 14-15).

"withheld * * * certain 'heavy-care' Medicaid payments" (Pet. App. 1). Starting from that premise, the court explained (*id.* at 1-2) that under this Court's decision in *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), "42 U.S.C. § 1983 can provide a cause of action in federal court for the denial of rights created by a federal statute." The court of appeals acknowledged (Pet. App. 2) that this Court's subsequent decisions, such as *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1 (1981), had "narrowed [*Thiboutot*] as applied to some federal statutes." But the court surmised that the reasoning of those subsequent decisions does not apply to actions, like this one, "brought to compel participating states to comply with the provisions of the Social Security Act" (Pet. App. 2). The court therefore held (*ibid.*) that "actions which properly allege violations of 42 U.S.C. § 1396a(a)(13)(A) are entitled to consideration on the merits" and that "it was not necessary to engage in a *Pennhurst* analysis."

Alternatively, the court concluded that respondents may sue Oregon in federal court "[e]ven if *Pennhurst* properly applies," since, in the court's view, the instant case implicates neither of the exceptions to Section 1983 jurisdiction that *Pennhurst* noted. First, while acknowledging that "[s]pecific and detailed procedures for administrative and judicial review [may] foreclose or preclude recourse to § 1983," the court stated that the Medicaid Act does not provide remedies that are "sufficiently precise" or comprehensive enough "to preclude remedies otherwise properly available under § 1983." Pet. App. 3. Second, the court reasoned that respondents "can enforce 42 U.S.C. § 1396a(a)(13)(A)" because they are assertedly "the intended beneficiaries of the Medicaid statutes in general and [of that Section] in particular" (Pet. App. 3, 4-5). The court accordingly held that Section 1396a(a)(13)(A) creates

an enforceable right in respondents for purposes of 42 U.S.C. 1983.[5]

SUMMARY OF ARGUMENT

The court of appeals' decision rests on three premises, each as fragile as the next. The court first held that respondents' complaint had stated a "cognizable claim for statutory entitlement" under Section 1396a(a)(13)(A) simply by alleging that Oregon "withheld * * * certain 'heavy-care' Medicaid payments." Pet. App. 1. From that initial premise the court reasoned that under *Thiboutot* a Section 1983 claim will automatically lie, regardless of the exceptions identified in *Pennhurst*. Finally, the court surmised that, assuming *Pennhurst* is relevant at all, Section 1396a(a)(13)(A) creates "enforceable rights" in respondents because respondents are among the "intended beneficiaries" of that provision. Pet. App. pp. 4.

None of these premises holds its ground. First, if the court of appeals' reading of respondents' complaint is correct, then the complaint fails for want of federal jurisdiction, since no part of the complaint would implicate federal law. Second, there is no support in this Court's

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[5] The court of appeals did not address whether, and to what extent, respondents would be entitled to a remedy if they were to prevail on the merits following remand. We note, however, that the Eleventh Amendment would plainly rule out respondents' prayer for retroactive damages against Oregon (see, *e.g.*, *Edelman* v. *Jordan*, 415 U.S. 651 (1974)), as well as against petitioner Ladd "if 'the judgment sought would expend itself on the public treasury or domain' " (*Dugan* v. *Rank*, 372 U.S. 609, 620 (1963) (citation omitted)). Moreover, respondents' claim for injunctive relief against the Department would seem to be barred as well. As this Court has observed, "in the absence of consent a suit in which * * * one of [the State's] agencies or departments is named as the defendant is proscribed by the Eleventh Amendment" and this is true "regardless of the nature of the relief sought" (*Pennhurst State School & Hosp.* v. *Halderman* (*Pennhurst II*), 465 U.S. 89, 100 (1984) (citations omitted)).

decisions for the idea that the *Pennhurst* analysis is generically inapplicable in litigation concerning the Social Security Act. Third, if one assumes that there is a plausible reading of respondents' complaint that does invoke federal law, their claim again fails, because Section 1396a(a)(13)(A) simply does not create "enforceable rights" in respondents for purposes of Section 1983. The language of Section 1396a(a)(13)(A) does not establish a mandatory obligation that is suited to private enforcement; and the history of the Section, and its construction by the Secretary, reveal that Congress did not intend to establish such enforceable rights. Respondents seek to transform what is, at bottom, a typical Medicaid reimbursement dispute under state law into a federal controversy under Section 1983, and the court of appeals' decision permitting that transformation should be reversed.[6]

ARGUMENT

THE COURT OF APPEALS ERRED IN HOLDING THAT RESPONDENTS MAY SUE THE STATE OF OREGON UNDER SECTION 1983 FOR AN ALLEGED VIOLATION OF 42 U.S.C. 1396a(a)(13)(A)

A. As a Threshold Matter, It is Unclear That Respondents Have Actually Pleaded A Violation Of The Social Security Act

Under 42 U.S.C. 1983, any person who is deprived "of any rights, privileges, or immunities secured by the Constitution and laws" by a person acting under color of state law may bring a private action to seek redress. In *Maine* v.

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[6] Because Section 1396a(a)(13)(A) does not create an enforceable right for purposes of 42 U.S.C. 1983, there is no need for this Court to reach the question whether Congress, by mandating state administrative review procedures under Section 1396a(a)(37)(B), has created alternative remedies sufficient to foreclose enforcement through 42 U.S.C. 1983. See *Pennhurst*, 451 U.S. at 28; *Middlesex County Sewerage Auth.* v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981).

Thiboutot, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in Section 1983 must be read literally, so as to create a private cause of action against state officials for violations of rights created by federal statutes. In this case, the court of appeals concluded that respondents did in fact plead a violation of the Social Security Act by alleging that Oregon officials had "withheld from [respondents] certain 'heavy-care' Medicaid payments and reimbursements" (Pet. App. 1, 5).

As a threshold matter, we confess some uncertainty about whether respondents have actually pleaded a violation of the Social Security Act in this case. The court of appeals seems to have believed (Pet. App. 1) that respondents sufficiently pleaded a federal statutory violation simply by alleging that Oregon should have reimbursed Coos Bay Center at a higher rate for services rendered to particular individuals. Under that view, however, virtually any disagreement over a state Medicaid reimbursement decision would give rise to a Section 1983 cause of action. Plainly, that cannot be so. As this Court has stressed in a related context, an action can be deemed to "arise under" the laws of the United States only if the plaintiff establishes, at a minimum, "that its right to relief under state law requires resolution of a substantial question of federal law in dispute between the parties" (*Franchise Tax Board* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 13 (1983) (construing 28 U.S.C. 1331)). Where the only issue in dispute between the parties is whether the State has correctly construed its own Medicaid plan, no question of federal law is even implicated, let alone as "a necessary element of one of the well-pleaded state claims" (*ibid.*); see also *Merrell Dow Pharmaceuticals Inc.* v. *Thompson*, No. 85-619 (July 7, 1986), slip op. 9; *Gully* v. *First Nat'l Bank*, 299 U.S. 109, 115 (1936).

The mere fact that Oregon adopted its plan in order to participate in the federal Medicaid program, moreover, cannot convert into a federal statutory violation what is, at

bottom, only a dispute about the proper application of state law. As the Second Circuit noted in *Oberlander* v. *Perales,* 740 F.2d 116, 119 (1984), there is "no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law." See also *Merrell Dow Pharmaceuticals Inc.*, slip op. 10-11 n.12; *Shulthis* v. *McDougal,* 225 U.S. 561, 569-570 (1912); *Shoshone Mining Co.* v. *Rutter,* 177 U.S. 505, 507 (1900).

If respondents in fact have pleaded merely a violation of state law in this case, that defect is obviously fatal to their claim of federal jurisdiction. As this Court held in *Pennhurst State School & Hosp.* v. *Halderman* (*Pennhurst II*), 465 U.S. 89, 106 (1984), "it is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law." "Such a result," the Court stated, "conflicts directly with the principles of federalism that underlie the Eleventh Amendment" (465 U.S. at 106).

Apparently recognizing the vulnerability of the court of appeals' view of their complaint, respondents have ventured (Br. in Opp. 14) a different characterization. "The crux of the Complaint in this case," respondents say, "was that the payment rates established by Oregon pursuant to its participation in the Medicaid program were not reasonable or adequate," in purported violation of the standard set by Section 1396a(a)(13)(A). But this characterization of the complaint founders on the fact that Section 1396a(a)(13)(A) does not establish an objective federal standard of "reasonable reimbursement" to which participating States must conform. Indeed, as we explain below, Section 1396a(a)(13)(A) leaves it to the States to determine what level of reimbursement is "reasonable," and the legislative history shows that Congress deliberately sought to avoid imposing on the States an inflexible federal standard in this respect.

B. Even If Respondents Have Sufficiently Pleaded A Violation Of 42 U.S.C. 1396a(a)(13)(A), That Section Does Not Create Enforceable Rights Under Section 1983

1. There is no Section 1983 cause of action to enforce a federal statute unless Congress intended the statute to create enforceable rights

a. One year after its decision in *Thiboutot*, this Court, in its first *Pennhurst* decision, "recognized two exceptions to the application of § 1983 to statutory violations." *Middlesex County Sewerage Auth.* v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981), citing *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1 (1981). In particular, the Court held that a Section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under Section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright* v. *City of Roanoke Redevelopment & Housing Auth.*, No. 85-5915 (Jan. 14, 1987), slip op. 5.

The contours of the "enforceable rights" exception were laid out in *Pennhurst* itself. The plaintiffs there brought an action under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6000 *et seq.*, to challenge the conditions at a state-operated facility for the mentally retarded. Plaintiffs relied on several sections of the Act. The first of these, Section 6010 (the so-called "bill of rights" provision), set out a series of "findings respecting the rights of persons with developmental disabilities" (42 U.S.C. 6010 (quoted in 451 U.S. at 13)). Plaintiffs also relied on provisions of the Act that required participating States, as a condition of the receipt of federal funds, to make "assurances" to the Secretary that they had a habilitation plan in effect for the retarded (Section 6011) and that their programs protected their patients' human rights (Section 6063(b)(5)(C)).

Rejecting plaintiffs' claims, the Court held, first, that Section 6010 "does not create substantive rights" and "does no more than express a congressional preference for certain kinds of treatment" (451 U.S. at 11, 19). Rather than imposing "binding obligations on the States," the Court explained, Section 6010 "spoke merely in precatory terms" and simply offered "congressional 'encouragement' of state programs" (451 U.S. at 18, 27). Turning to Sections 6011 and 6063(b)(5)(C) of the Act, which the courts below had not addressed, this Court remanded to the court of appeals for further consideration (451 U.S. at 30). But the Court noted that plaintiffs under those Sections "can claim only that the state plan has not provided adequate 'assurances' to the Secretary" (*id.* at 28). "It is at least an open question," the Court stated, "whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983" (451 U.S. at 28).

The Court applied the "enforceable rights" exception more recently in *Wright* v. *City of Roanoke Redevelopment and Housing Auth.*, No. 85-5915 (Jan. 14, 1987). In that case, tenants living in housing projects owned by a city redevelopment authority brought suit under Section 1983, alleging that the city had violated a rent ceiling imposed by the Brooke Amendment to the Housing Act of 1937, Pub. L. No. 91-152, § 213, 83 Stat. 389, and implementing HUD regulations. The Court held that the Brooke Amendment did create "enforceable rights," explaining that the Amendment "could not be clearer" in setting an upper limit on chargeable rents and in establishing "a mandatory limitation focusing on the individual family and its income" (slip op. 12). The Court also stated that the standard set by the Amendment and its acompanying regulations was not "too vague and amorphous to confer on tenants an enforceable 'right,' " since the Amendment and regulations, taken together, "specifically set out

guidelines that the [housing authorities] were to follow" (*id.* at 13). The Court accordingly determined that "the benefits Congress intended to confer on tenants are sufficiently specific and definite to qualify as enforceable rights under *Pennhurst* and § 1983" (slip op. 13-14).

The court of appeals in the instant case concluded that "it was not necessary to engage in a *Pennhurst* analysis," hypothesizing that "*Thiboutot* still governs actions brought to compel participating states to comply with the provisions of the Social Security Act" (Pet. App. 2). The court of appeals' conclusion does not follow from its premise. It is true, of course, that *Thiboutot* "governs" this action in the sense that *Thiboutot* holds that statutory violations may give rise to Section 1983 claims. But *Pennhurst* qualified that governing principle, and this Court has never suggested that the two exceptions recognized in *Pennhurst* are for some reason inapplicable when the statute in question is the Social Security Act. Indeed, since *Pennhurst* was decided, this Court has routinely applied the two *Pennhurst* exceptions, without once intimating that those exceptions apply only to certain statutes but not others. See *Wright,* slip op. 5; *Sea Clammers,* 453 U.S. at 19. See also *Silver* v. *Baggiano,* 804 F.2d 1211, 1215-1218 (11th Cir. 1986) (applying *Pennhurst* exceptions to a Section 1983 claim under the Social Security Act). Contrary to the court of appeals' statement, therefore, it is "necessary to engage in a *Pennhurst* analysis."

b. In deciding whether a federal statute creates "enforceable rights" under *Pennhurst,* a court may not—as the court of appeals did in this case (Pet. App. 4)—ask simply whether the plaintiffs are the "intended beneficiaries" of the particular statute. Certainly, persons with developmental disabilities were the "intended beneficiaries" of the statute at issue in *Pennhurst,* but this Court's opinion makes clear that that is not sufficient. A statute may intentionally benefit a particular person or

class of persons, without creating "specific and definite" rights on their part (*Wright*, slip op. 14), and without designating them as the appropriate agents to enforce whatever rights exist. See Brown, *Pennhurst As A Source Of Defenses For State And Local Governments,* 31 Cath. U.L. Rev. 449, 459 (1982). In determining whether private parties may sue to enforce a statute, this Court has stated, "[t]he question is not simply who would benefit from the Act, but whether Congress intended to confer rights upon those beneficiaries" (*California* v. *Sierra Club,* 451 U.S. 287, 294 (1981)). In answering this question, a court must look, as this Court did in *Pennhurst* and in *Wright,* to the language and history of the statute to discern whether Congress clearly intended to create a "specific and definite" right and to authorize private enforcement of that right. Several principles should guide the court's approach.

First and foremost, the language of the statute must be mandatory and narrow in order to create an enforceable right. As this Court has explained in a related context, the "right- or duty-creating language of the statute has generally been the most accurate indicator of the propriety of implication of a cause of action" (*Cannon* v. *University of Chicago,* 441 U.S. 677, 690 n.13 (1979)). The courts must therefore "distinguish statutory provisions that announce broad policy goals or general preferences from those that dictate specifically what the relevant governmental officials may and may not do" (*Edwards* v. *District of Columbia,* No. 85-6150 (D.C. Cir. June 12, 1987), slip op. 11). Applying that distinction, "the courts of appeals in the aftermath of *Pennhurst* have, for the most part, upheld rights claims in statutes that dictate specific action and leave little room for choice, while rejecting rights claims in statutes that merely indicate broad preferences" (*ibid.*). This Court itself has recently stated that a statutory obligation must be "specific and definite" in

order to create an enforceable right (*Wright,* slip op. 14), and the courts of appeals have similarly reasoned that the statute must be "cast in the imperative" (*Alexander* v. *Polk,* 750 F.2d 250, 259 (3d Cir. 1984)), and must "clearly impose[] an affirmative obligation" (*Polchowski* v. *Gorris,* 714 F.2d 749, 751 (7th Cir. 1983)).[7]

Second, a court must consider the nature of the federal standard imposed by the statute. Where, for example, the statute imposes an open-ended standard of "reasonableness," a court should be reluctant to conclude that Congress intended to authorize federal courts to superintend a state's compliance with that standard. See generally Sunstein, *Section 1983 and the Private Enforcement of Federal Law,* 49 U. Chi. L. Rev. 394, 428-430 (1982).

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[7] The D.C. Circuit's recent decision in *Edwards* v. *District of Columbia, supra,* demonstrates, in our view, an appropriate consideration of statutory language in applying the "enforceable rights" exception. Plaintiffs there sued a local public housing agency for its alleged failure to comply with certain conditions imposed by federal law for the demolition of a federally funded housing project. Although the Secretary of HUD had not approved an application to demolish the project, plaintiffs asserted that the statutory conditions on demolition imposed independent duties on the local agency that tenants were entitled to enforce under Section 1983. The court of appeals rejected the claim and ordered dismissal of the complaint. Concluding that the federal housing statute did not create an enforceable right, the court properly distinguished between "broad policy goals" and mandatory, right-creating provisions (slip op. 11):

> While policy goals and general preferences leave much room for governmental officials to determine the means by which these goals and preferences are to be carried out, and therefore are ambiguous regarding what duties are owed to which citizens, specific language of obligation narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people.

The court reviewed the language and legislative history of the statute and held that the obligations relied on by the plaintiffs were simply conditions precedent to the Secretary's grant of a demolition application; they did not create enforceable obligations independent of the application process.

Especially is that so where, as here, Congress has expressly provided for administrative review of claims by state agencies under such a "reasonableness" formula. See 42 U.S.C. 1396a(a)(37)(B); cf. *Universal Camera Corp.* v. *NLRB,* 340 U.S. 474, 487-491 (1951). State administrative agencies, which deal on a day-to-day basis with the intricacies of their own grant programs, are obviously well suited to ascertain what is "reasonable" under all the circumstances, and that fact should make a federal court particularly reluctant to second-guess the State's assessment.

2. ***Section 1396a(a)(13)(A) was not designed to create enforceable rights for purposes of 42 U.S.C. 1983***

a. Section 1396a(a)(13)(A) does not read like a statute designed to "dictate specifically what the relevant governmental officials may and may not do" (*Edwards,* slip op. 11). Far from containing "right- or duty-creating language" (*Cannon* v. *University of Chicago,* 441 U.S. at 690 n.13), Section 1396a(a)(13)(A) permits participating States to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *." The statute further provides that such rates may be set "in accordance with methods and standards developed by the State." By its terms, therefore, Section 1396a(a)(13)(A) vests rate-making discretion entirely in the States, subject only to the condition that they make "assurances" satisfactory to the Secretary. As this Court wrote in *Pennhurst*, "[i]t is at least an open question whether an individual's interest in having a State provide * * * 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983" (451 U.S. at 28).

Moreover, the standard of "reasonableness" set forth in the statute shows that Congress did not intend the federal

courts to monitor the States' compliance by way of Section 1983. This Court in *Wright* concluded that the Brooke Amendment and its implementing regulations created enforceable rights because they "specifically set out guidelines that the [housing authorities] were to follow in establishing utility allowances" (slip op. 13). Here, by contrast, Section 1396a(a)(13)(A) provides in general terms that the State must find, and assure the Secretary, only that its reimbursement rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws * * *." The implementing regulations reiterate this broad standard, leaving the States with freedom to structure reimbursement systems tailored to their own objectives.[8] Nowhere in the statute can one find the "specific language of obligation [that] narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people" (*Edwards,* slip op. 11). Rather, "[t]he subsection is essentially administrative in nature" (*Polchowski* v. *Gorris,* 714 F.2d at 751), entrusting to the individual States the duty to define and implement what is a "reasonable" reimbursement system.

b. The legislative history of Section 1396a(a)(13)(A) confirms that Congress did not intend, as respondents suggest (Br. in Opp. 14), to create in Medicaid providers and their patients an enforceable right to "reasonable" reimbursement payments. To the contrary, the history of the statute reveals that Congress sought deliberately to avoid

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[8] Thus, 42 C.F.R. 447.252(a), on which respondents in their complaint relied (Pet. App. 34), provides simply that the state plan "must provide that the requirements of this subpart [implementing Section 1396a(a)(13)(A)] are met." 42 C.F.R 447.253, which elaborates the requirements for "state assurances" under Section 1396a(a)(13)(A), merely requires state Medicaid agencies to "make" * * * findings" that their Medicaid payment rates are "reasonable and adequate."

saddling state reimbursement decisions with cumbersome federal oversight. In view of that history, it cannot plausibly be contended that Congress expected private persons to enforce their own views of appropriate Medicaid rate-setting under the aegis of a Section 1983 action in federal court.

In 1972 Congress enacted a "reasonable cost" formula for making Medicaid reimbursements to intermediate care facilities like Coos Bay Center. Codified at the time in 42 U.S.C. (Supp. II 1972) 1396a(a)(13)(E), this statute required participating States to include in their Medicaid plans a provision "for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis." Social Security Amendments of 1972, Pub. L. No. 92-603, § 249(a), 86 Stat. 1426. This provision, linking reimbursement to facilities' actual costs, "was designed to assure that payment rates would more closely reflect the reasonable costs necessary to provide * * * services of adequate quality" (S. Rep. 96-471, 96th Cong., 1st Sess. 28 (1979)).

In 1979, however, Congress concluded that the "reasonable cost" reimbursement formula was no longer "entirely satisfactory" (S. Rep. 96-471, *supra*, at 28). Congress found that requiring States to adopt that formula had proved to be "inherently inflationary" and "contain[ed] no incentives for efficient performance" (*ibid.*). In 1980, therefore, Congress abandoned the "reasonable cost" reimbursement system and adopted the so-called Boren Amendment now embodied in Section 1396a(a)(13)(A). Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2650-2651.[9]

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[9] In 1981 Congress abandoned the "reasonable cost" reimbursement formula for hospitals as well, providing that hospitals, like nursing homes and intermediate care facilities, should be governed thenceforth by the revised standard now incorporated in 42 U.S.C.

The Boren Amendment "represented a significant change in the federal [reimbursement] standard," offering the States an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies" (*Wisconsin Hospital Ass'n* v. *Reivitz,* 733 F.2d 1226, 1228 (7th Cir. 1984)). Congress chose to "give[] the States flexibility and discretion * * * to formulate their own methods and standards of payment" (S. Rep. 96-471, *supra,* at 28-29).[10] By the same token, Congress intended that the degree of federal oversight should be significantly reduced. While pointing out that the Secretary would continue to insist on "assurances * * * that the payment rates * * * are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not overburden the States and facilities with marginal but massive paperwork requirements" (*id.* at 29).

In enacting the Boren Amendment, therefore, Congress made clear that it did not envision rigorous federal scrutiny of the States' "assurances" under Section 1396a(a)(13)(A). To the contrary, Congress "expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary." S. Rep. 96-471, *supra,* at 29. See

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1396a(a)(13)(A). See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173(a), 95 Stat. 808. See generally *Wisconsin Hospital Ass'n* v. *Reivitz,* 733 F.2d 1226, 1228 (7th Cir. 1984).

[10] There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion on the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17885-17886 (1980). The Boren Amendment does not materially differ from the provision contained in the 1979 bill. See S. Rep. 96-471, *supra,* at 157-158. For that reason, we have set out in the text the relevant portions of the Senate report that accompanied the 1979 bill.

also 126 Cong. Rec. 17886 (1980) (Sen. Boren) ("[P]ayment methods adopted by the States will carry a presumption of compliance."). ~~Indeed~~, the 1980 Conference Report stated that "[i]f, within 90 days of receiving the rates proposed to be used by a State, the Secretary has not made a final determination that the rates proposed meet all applicable requirements of medicaid law, then the rates would be presumed to meet the medicaid law requirements for the fiscal year for which they were imposed" (H.R. Conf. Rep. 96-1479, 96th Cong., 2d Sess. 154 (1980)). Consistently with this legislative history, the Secretary has maintained that Section 1396a(a)(13)(A) does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted.

The Boren Amendment, in short, was designed to promote two closely connected purposes. First, in order to reduce the cost of participating in the Medicaid program, the Amendment freed the States of the constraints previously imposed by the "reasonable cost" formula, and allowed state agencies "to establish rates on a statewide or other geographical basis, a class basis, or an institution-by-institution basis" (S. Rep. 96-471, *supra,* at 29). Second, the Amendment was intended to reduce the degree of federal oversight, on the theory that excessive federal scrutiny had "overburden[ed] the States and facilities with marginal but massive paperwork requirements" (*ibid.*). In light of these purposes—carefully reflected in the plain language of Section 1396a(a)(13)(A)—it is difficult to imagine that Congress intended to authorize federal courts, in actions brought against the States under Section 1983, to develop and apply a federal common law respecting the "reasonableness" of Medicaid reimbursement rates.

The legislative history of Section 1396a(a)(13)(A) thus confirms what its language clearly suggests—that Congress in enacting that statute did not intend to confer on

Medicaid providers and patients an "enforceable right" to challenge state reimbursement decisions in federal court. Lawsuits like respondents' interfere with state autonomy and discretion, and they contravene Congress's intent that the degree of federal oversight should be minimized. There is no reason to believe that Congress wished the participating States to absorb the substantial costs entailed by such litigation.[11]

c. This Court observed in *Wright* (slip op. 9) that "HUD's opinion as to available tenant remedies under the Housing Act is entitled to some deference by th[e] Court."

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[11] Four years prior to the Boren Amendment, Congress had amended the Social Security Act to repeal 42 U.S.C. (Supp. V 1975) 1396a(g), a provision that had required participating States to waive their Eleventh Amendment immunity from suits brought with respect to Medicaid payment for inpatient hospital services. Act of Oct. 18, 1976, Pub. L. No. 94-552, 90 Stat. 2540; see H.R. Rep. 94-1122, 94th Cong., 2d Sess. 1 (1976); S. Rep. 94-1240, 94th Cong., 2d Sess. 1 (1976). Congress repealed that provision, which had been enacted just the previous year, because it had "require[d] States to waive one of their basic rights" and had resulted in "an unreasonable burden of suits which [had been] costly in terms of time and legal manpower, and which [had made] efficient program administration virtually impossible" (H.R. Rep. 94-1122, *supra*, at 4). The House and Senate reports observed in passing that, after the repeal, "providers can continue * * * to institute suit for injunctive relief in State or Federal courts, as necessary." *Id.* at 7 (letter from Department of HEW); S. Rep. 94-1240, *supra*, at 4. These remarks, however, cannot determine the availability of a Section 1983 cause of action under Section 1396a(a)(13)(A) as it now exists. As noted above (page 18 and note 9, *supra*), Congress substantially revised that Section in 1980 and 1981 for the express purpose of conferring greater discretion upon the individual States in structuring their reimbursement systems, while at the same time reducing significantly the degree of federal oversight. Whatever federal remedies may have been available to Medicaid providers under the old "reasonable cost" reimbursement system, therefore, did not survive Congress's substantial revision of Section 1396a(a)(13)(A) in 1980.

See also *Cannon* v. *University of Chicago,* 441 U.S. at 687-688 & n.8, 701, 702. In the present case, the Secretary has considered the availability of private rights of action to enforce Section 1396a(a)(13)(A) and has concluded that no such rights exist.

In September 1981 the Secretary published interim final regulations designed to implement the legislation now codified in Section 1396a(a)(13)(A). See 46 Fed. Reg. 47964. In December 1983, after receiving public comments on those interim final rules, the Secretary published a set of revised regulations. See 48 Fed. Reg. 56046. The Secretary also set out a "preamble" designed to address the "concerns raised in the[] comments" (*id.* at 56047).

One commentor had addressed the precise issue presented in this case. He proposed that the federal government "require States to provide judicial recourse for providers dissatisfied with State payment rates" (48 Fed. Reg. 56052 (1983)). The Secretary rejected that suggestion (*ibid.*), concluding that there was no statutory license to impose such a requirement on the States:

> [A]bsent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available in their States after they have exhausted the administrative appeal process.

The Secretary's conclusion that federally mandated "judicial recourse" is both unwarranted and unwise is entitled to deference in deciding whether Congress intended to authorize private actions to challenge state Medicaid reimbursement decisions under Section 1983.[12]

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[12] The Secretary's conclusion that judicial enforcement actions are inappropriate is consistent with his more general determination, stated

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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throughout the preamble to the final regulations, that the federal government should avoid excessive interference with the States' rate-setting authority under the Medicaid program. For example, several commentors had proposed that the Secretary "be more explicit as to [the federal] criteria for review of State assurances" (48 Fed. Reg. 56050 (1983)). The Secretary rejected this suggestion (*ibid.*), finding that "such a list of criteria may be viewed as imposing Federal standards for payment rates, an effect that would be contrary to the legislative intent." For the same reason, the Secretary rejected a proposal that the federal government define the term "efficiently and economically operated facility" as used in Section 1396a(a)(13)(A). See 48 Fed. Reg. 56049 (1983). As the Secretary put it (*ibid.*), "we believe any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute."

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No. 86-1419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

Brief of the States of Colorado, Hawaii, Idaho, Indiana, Kansas, Maine, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin, as *Amici Curiae* in Support of Petitioners

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IN THE

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OCTOBER TERM, 1986

No. 86-1419

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

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vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

BRIEF OF THE STATES OF COLORADO, HAWAII, IDAHO, INDIANA, KANSAS, MAINE, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NEW MEXICO, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, TENNESSEE, UTAH, VERMONT, VIRGINIA, WASHINGTON, AND WISCONSIN, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 36.4 of the Rules of this Court, the States of Colorado, Hawaii, Idaho, Indiana, Kansas, Maine, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin, as amici curiae,

respectfully submit this brief in support of the petition for writ of certiorari submitted by the State of Oregon Department of Human Resources seeking review of the decision of the United States Court of Appeals for the Ninth Circuit issued November 3, 1986, 803 F.2d 1060 (9th Cir. 1986), reversing the United States District Court for the Western District of Oregon, and finding that respondents' complaint states a claim for which relief may be granted under the Civil Rights Act of 1871, 42 U.S.C. § 1983.

INTEREST OF THE AMICI CURIAE

Each of the amici States participates in the Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, and in that manner provides medical assistance to needy eligible persons who are unable to provide for their medical care from their own resources.

As required by federal law, the programs of each of the amici States encompass institutional medical care. The amici provide in-patient hospital, skilled nursing facility, and intermediate care facility services under their federally-approved Medicaid plans. Medical care provided in these institutional settings comprises a major element of the Medicaid programs of these States, as in most States in the Nation.

Providers of institutional medical care who contract with the States are reimbursed according to each State's Medicaid plan. Federal law requires that the States reimburse providers through rates that the States determine to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." 42 U.S.C. § 1396a(a)(13) (1982 & Supp. III 1985). Federal law

also requires states participating in Medicaid to establish administrative review procedures for providers who wish to challenge our reimbursement decisions. 42 C.F.R. § 447.253(c) (1986).[1] Federal regulations similarly mandate the States to provide hearing rights to Medicaid applicants and recipients who believe the States have not granted them appropriate benefits. 42 C.F.R. §§ 431.220(a), 431.241(a)-(b). Numerous States, in implementing these federally mandated protections, require that the results of Medicaid review hearings be subject to judicial review in State courts under procedures akin to those provided by federal law when federal agencies set and apply reimbursement rates. *See* K. Davis, *Administrative Law* § 1:11 (Supp. 1982) (administrative procedure acts); *cf. Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133 (1986); *Heckler v. Ringer,* 466 U.S. 602 (1984); *United States v. Erika, Inc.,* 456 U.S. 201 (1982).

This case affords the Court an opportunity to consider the availability of 42 U.S.C. § 1983 as a remedy for providers of institutional care who contract with the States and seek review of the States' reimburse-

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[1] These administrative appeal procedures are set forth, for example, at Alaska Stat. § 47.07.075 (1984); Cal. Welfare and Institutions Code § 14087.27 (1987); Haw. Admin. R. § 17-748 (1985); Idaho Code, §§ 56-132, -133 (1986); Kan. Stat. Ann. § 75-3306 (1984): Maine Med. Assistance Manual § 1.18 (1979); Mo. Rev. Stat. §§ 208.156, 621.055 (1983); Nev. Medicaid Services Manual § 506 (1987); N.C. Admin. Proc. Act, Articles 3 and 4, Chapter 150B (1986). N.D. Admin. Code § 75-02-06-16(7) (1986); Ohio Rev. Code § 5111.06 (1981); Vt. Stat. Ann. Tit. 33, § 195 (1978); Utah Code Ann. § 26-23-2 (1984); Va. Code § 9-6.14:1 (1985); Wash. Rev. Code § 74.46.770 (1987); Wis. Stat. § 227.42 (1985-86).

ment decisions. Medicaid providers are certainly entitled to have their state reimbursement decisions reviewed, but that entitlement does not imply that the Civil Rights Act of 1871 should be the vehicle for that process. The amici States believe that Congress's intent in developing the Medicaid program was to allow provider reimbursement review at the state administrative level and not in federal court.

The amici have a vital interest in the resolution of this case. Each of us makes reimbursement decisions annually, if not biennially, to thousands of Medicaid providers in our respective States. Each of us, as well as all remaining States that participate in Medicaid, have administrative review procedures for institutional providers that seek review of reimbursement decisions. These diverse procedures, which are designed in light of State administrative practice, but subject to federal review by the Secretary of Health and Human Services, will be disrupted, if not completely thwarted, if § 1983 is applied according to the decision in *Coos Bay Care Center v. Oregon.*

These substantial interests warrant the submission of this amici brief in support of Oregon's efforts to obtain review by this Court of the lower court's decision that Medicaid institutional providers may seek federal court review, through § 1983, of the States' reimbursement decisions.

SUMMARY OF ARGUMENT

Providers of institutional medical care who contract with the States to provide services to Medicaid recipients are not entitled under 42 U.S.C. § 1983 to seek federal court review of State Medicaid reimbursement decisions. This is true both because Con-

gress and the Secretary of Health and Human Services have directed that Medicaid reimbursement decisions be reviewed in State administrative proceedings, subject to those added review mechanisms that the States provide, and because, at least once the State medicaid plan is in place, providers, as opposed to recipients, do not enjoy any federal "rights, privileges, or immunities," with respect to reimbursement.

The degree to which the Ninth Circuit's decision vastly expands the reach of § 1983 as a vehicle for bypassing federally-mandated administrative proceedings in States across the Nation warrants plenary review by this Court.

ARGUMENT

This Court has made plain that there are ". . . two exceptions to the application of § 1983 to remedy statutory violations: where Congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges or immunities within the meaning of § 1983." *Wright v. City of Roanoke Redevelopment & Housing Authority,* 107 S.Ct. 766, 770 (1987) (citing *Pennhurst State School and Hosp. v. Halderman,* 451 U.S. 1, 19 (1981); *Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n,* 453 U.S. 1 (1981); *Smith v. Robinson,* 468 U.S. 992 (1984)).

The lower court's conclusion that neither of these exceptions applied to Medicaid reimbursement decisions, Pet. App. A-3, A-4, completely ignored the reasons why the federal Government has mandated *state* procedures as the vehicle for challenging such decisions, as well as numerous decisions by the lower

courts that reaffirm that "[t]he health care practitioner 'is not the intended beneficiary of the Medicaid program.' " *Silver v. Baggiano,* 804 F.2d 1211, 1216 n.3 (11th Cir. 1986) (quoting *Geriatrics, Inc. v. Harris,* 640 F.2d 262, 265 (10th Cir.), *cert. denied,* 454 U.S. 832 (1981); *Green v. Cashman,* 605 F.2d 945, 946 (6th Cir. 1979)).

I.

In sweeping away the States' procedural processes for adjudicating reimbursement decisions, the Ninth Circuit adopted a view of those procedures that is demonstrably wrong. Whereas the court held that "Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements," Pet. App. at A-3 (emphasis added), the federal regulations are inalterably mandatory: each state is required to provide ". . . an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review . . . ." 42 C.F.R. 447.253(c).

The consequences of allowing a Medicaid provider to bypass these processes are enormous. As this Court held last Term, it is common in entitlement programs to preclude *entirely* judicial review of individual reimbursement decisions, so as to " ' "avoid overloading the courts" ' with ' "trivial matters," ' a consequence which would ' "unduly ta[x]" ' the federal court system with ' "little real value" ' to be derived by participants in the program[.]" *Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133, 2138 (1986) (quoting *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982) (quoting legislative history)).

A State administrative hearing is the most appropriate forum for considering the fairness of provider reimbursement decisions. Medicaid reimbursement decisions are based on extensive technical material. These decisions are best judged through administrative appeals procedures such as those that have been established by the States. As Congress and the Secretary intended, State appeal processes have been carefully tailored to local conditions in recognition of the highly technical nature of Medicaid reimbursement decisions.

The lower court's decision also poses a substantial obstacle to Congress's repeatedly stated expectation that federal review procedures be "less administratively burdensome" upon the States. *See* 48 Fed. Reg. at 56047 (1983). Requiring the States to defend reimbursement decisions in federal court greatly increases administrative cost because the States have spent their resources, as they must, in providing State administrative remedies for the Medicaid providers.

The Ninth Circuit's decision in this case is particularly disturbing because here, as in *Erika,* there is strong indication that the federal government intended to bar resort to the lower federal courts. As the Secretary stated in 1983, "absent any statutory mandate, there is no Federal authority to require judicial recourse (presumably [even] in State courts) for providers dissatisfied with State payment rates." 48 Fed. Reg. 56046, 56052 (1983) (emphasis added).

In addition, Congress and the Secretary recognized that, in most States, as in Oregon, there would be judicial review as to these statutory issues by a *state* court. Most States, like Oregon, have administrative procedure acts that ensure that agency action com-

plies with relevant administrative directives, including, for example, requirements of the State Medicaid plan. As the Secretary stated in promulgating the procedural requirements for Medicaid plans, "providers are free to pursue whatever judicial remedies are available in their *States* after they have exhausted the administrative appeal process." 48 Fed. Reg. at 56052 (emphasis added). That statement should have sufficed to preclude § 1983 claims by Medicaid providers and applicants as to particular reimbursement decisions. *Compare Wright,* 107 S. Ct. at 772 (§ 1983 review is available in part because Secretary stated explicitly that federal regulation " 'does not preclude Federal court review' ").[2]

Believing "that fair and reasonable rate adjustments are implicit in a [state] appeals' process," Congress and the Secretary explicitly endorsed granting States broad discretion in developing their review procedures, and thus saw "no need for . . . prescriptive Federal requirement[s]." 48 Fed. Reg. 56052 (1983). By allowing providers to bypass these review proce-

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[2] Of course, it was not necessary for Oregon to succeed on a claim that Congress precluded § 1983 review entirely. In addition, the court of appeals should have affirmed if Medicaid reimbursement falls within that group of claims as to which Congress has intended to abrogate the general rule that exhaustion of administrative remedies is not required under § 1983. *See Wright,* 107 S. Ct. at 773; *Patsy v. Board of Regents,* 457 U.S. 496, 507-512 (1982). The Ninth Circuit unjustifiably refused even to consider whether, in light of the well-established rules requiring exhaustion in federally-administered medical assistance programs, *see Heckler v. Ringer,* 466 U.S. 602, 612 (1984), Congress should be deemed to have intended a more burdensome process of wide-open judicial review for those federal programs administered by the States.

dures, the Ninth Circuit nullified this broad discretion established pursuant to federal direction by making our review procedures meaningless whenever a provider invokes § 1983.

II.

The Ninth Circuit erred just as egregiously in assuming that institutional care providers who contract with the States are beneficiaries of the Social Security Act and, accordingly, that § 1983 was available even if the federal Government had not "forceclosed such enforcement of the statute in the enactment itself." *Wright,* 107 S. Ct. at 770. As the Second Circuit held in *Oberlander v. Perales,* 740 F.2d 116, 119 (2d Cir. 1984), "there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law." *See also Case v. Weinberger,* 523 F.2d 602, 607 (2d Cir. 1975) ("benefits to a nursing home from its participation in Medicaid reimbursement result from nothing more than a statutory business relationship").

The only "rights" that Medicaid providers may be entitled to under the Social Security Act are rights to reimbursement ". . . which the state finds . . . are reasonable and adequate . . ." 42 U.S.C. § 1396a(a)(13)(A).[3] Such language is not the language

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[3] The institutional provider is of course free to stay out of the Medicaid program, *see Minnesota Assn. of Health Care Facilities v. Minn. Dept. of Public Welfare,* 742 F.2d 442, 446 (8th Cir. 1984). Because Medicaid providers voluntarily contract with the States, the States will be careful to avoid errors so as to encourage the broadest participation. Nor can there be any "tak-

of rights. Indeed, the lower court decisions on which the panel below relied held that this language is enforceable by § 1983 only with respect to the *procedural* requirements that must be met before a State's Medicaid plan will be deemed valid under federal law. *See Nebraska Health Care Ass'n v. Dunning,* 778 F.2d 1291 (8th Cir. 1985), *cert. denied,* 107 S. Ct. 947 (1987); *Washington State Health Facilities Ass'n v. State of Washington Dep't of Social & Health Servs.,* 698 F.2d 964 (9th Cir. 1982); *California Hospital Ass'n v. Obledo,* 602 F.2d 1357 (9th Cir. 1979). Even if these lower court decisions are correct, which we doubt, the Ninth Circuit here went far beyond such a rationale. Rather, the court below held that the Social Security Act establishes *substantive federal* rights allowing providers to block under § 1983 any administrative action that can be pleaded as a violation of the State Medicaid plan.

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ing" of vested rights where, as here, medical care providers prospectively refuse to provide services out of fear that they will not be reimbursed, and, for that reason, patients "do not receive the full amount of appropriate care." Pet. App. 35. *See F.C.C. v. Florida Power Corp.,* 55 U.S.L.W. 4236, 4238 (U.S. Feb. 25, 1987); *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 796 (1980) (Blackmun, J., concurring in the judgment); *Kizas v. Webster,* 707 F.2d 524, 539 (D.C. Cir. 1983), *cert. denied,* 464 U.S. 1042 (1984). This is so because there can be no "taking" of property by rate regulation unless "private property [has been] devoted to public uses[,]" and allowed rates are "confiscatory." *Florida Power,* 55 U.S.L.W. at 4238. *See also MacDonald Sommer, & Erates v. Yolo County,* 106 S. Ct. 2561, 2568 n.8 (1986) (taking claimants must make "meaningful" efforts to seek exemptions). The court of appeals recognized this truth, but then went on to sanction broad statutory challenges to reimbursement decisions. *Cf. United States v. Riverside Bayview Homes,* 106 S. Ct. 455 (1985).

Thus, although the providers in the lower court did not allege that Oregon failed to comply with the procedural requirements for the approval of Medicaid plans, the court of appeals nevertheless allowed wide-open litigation in the federal courts under § 1983 over whether States have "violate[d] the standard set out in 42 U.S.C. § 1396a(a)(13)(A)." Pet. App. 5. This broad reading of the Social Security Act unduly extends the "enforceable rights, privileges, and immunities," established by the Act, and opens the federal courts to a flood of lawsuits by institutional providers. *Cf. Block v. Community Nutrition Institute,* 467 U.S. 340, 352 (1984). Moreover, as petitioners have ably demonstrated, the Ninth Circuit's decision creates a gaping conflict with the Second Circuit's decision in *Oberlander v. Perales,* 740 F.2d 116, 119 (2d Cir. 1984), and with the jurisdictional principles of *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89 (1984). These conflicts merit plenary review by this Court.

CONCLUSION

Amici have sought to show that providers of institutional medical care who contract with the States to provide services to Medicaid recipients are not entitled under 42 U.S.C. § 1983 to federal court review of the merits of state Medicaid reimbursement decisions. Amici respectfully urge the Court to grant Oregon's petition, and to undertake plenary review of the decision below, which in unprecedented fashion disrupted a carefully tailored federal scheme that provides federal aid to the States in our efforts to expand the availability of medical care to those in our communities who are unable to afford it.

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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, U.S. CONFERENCE OF MAYORS, NATIONAL LEAGUE OF CITIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, AND NATIONAL CONFERENCE OF STATE LEGISLATURES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

Whether Oregon's Medicaid plan, defining a class of patients for whom supplemental reimbursement is available at a "heavy cost care" rate, confers on health care providers and recipients a federal right enforceable under 42 U.S.C. § 1983.

Whether 42 U.S.C. § 1983 provides a federal court remedy for additional reimbursement under Oregon's Medicaid plan to claimants who have bypassed the congressionally mandated administrative review procedures included in the plan.

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, U.S. CONFERENCE OF MAYORS, NATIONAL LEAGUE OF CITIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, AND NATIONAL CONFERENCE OF STATE LEGISLATURES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

The *amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States. *Amici* and their members have a compelling interest in legal issues that affect state and local governments.

This case is of importance to *amici* because it is another example of the proliferation of actions filed under 42 U.S.C. § 1983 against States and their political subdivisions to vindicate alleged federal rights arising from federal grant programs. Such litigation disrupts the federal-state relationship under these programs and undermines the States' functions and prerogatives.

This case arises out of the State's administration of its Medicaid program. Medicaid, a cooperative federal-state program that provides funds for medical services for the needy, leaves to each State the determination of eligibility requirements and reimbursement rates for patients and health care providers. The federal law and regulations evidence two concerns: to provide adequate health care to Medicaid recipients and to contain costs. Federal law requires each State to administer its plan through a special state agency and to establish administrative hearing processes to resolve disputes.

State plans are subject to review and approval by the United States Department of Health and Human Services. Oregon's plan, which has been approved, provides for reimbursement of long-term care facilities at a rate

of costs incurred by the lower 75% of all eligible facilities in Oregon. Oregon has also provided a special higher reimbursement rate for "heavy cost care" patients, defined as functional quadriplegics not requiring acute hospital care. Respondents' specific claim in this lawsuit is that Oregon incorrectly failed to classify certain patients as "heavy cost care" patients, and therefore failed to reimburse their health care providers at the higher "heavy cost care" rate. Respondents assert generally that the alleged misclassification of these patients violates their rights under constitutional, federal, and state law; but they can point to no specific violation of the detailed federal law and regulations.

The ruling below permits respondents to bypass state procedures established in accordance with federal law in order to assert in federal court rights that exist only by virtue of a state regulation. The decision turns every alleged misstep in the administration of a federal-state cooperative program into a federal case and exposes States and their political subdivisions to heavy potential financial liability. It also denigrates the state administrative procedures mandated by Congress by making the federal courts the initial claims agency for all dissatisfied Medicaid health care recipients and providers. Finally, it permits a federal court to define, in the first instance, a right that is a creature of state law. Thus, the decision below, in both its substantive and procedural aspects, poses a threat to the independence and integrity of the sovereign States in our federal system.

Amici submit that the decision below is wrong. Because this Court's decision will have a direct effect on matters of prime importance to *amici* and their members, *amici* submit this brief to assist the Court in its resolution of the case.[1]

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[1] Under Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk of the Court.

STATEMENT OF THE CASE

Respondent Coos Bay Care Center, Inc. ("Coos Bay") is in the business of providing long-term health care services for profit to developmentally disabled and aged residents at its intermediate care facility located in Coos Bay, Oregon. A portion of Coos Bay's revenues are derived from its participation in the Medical Assistance Program, 42 U.S.C. § 1396a *et seq.* ("Medicaid program"), administered by petitioner State of Oregon, Division of Human Resources ("DHR").[2] Coos Bay believes that it is entitled to more money from DHR.

Oregon, like every State, has citizens who cannot afford adequate health care. In order to assist these needy persons, Oregon chooses to participate in the Medicaid program, a federal-state partnership designed to provide health care services to the poor. *See Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). Under Medicaid, the federal government provides the bulk of the funding and general supervision of medical care of the needy, while the States actually develop, administer, and implement the program in accordance with their own state Medicaid plans, which must be approved by the Secretary of Health and Human Services ("HHS"). *Ibid.* If the terms or administration of the state plan do not conform to federal standards, the Secretary of HHS is authorized to withhold all or part of the federal funding. 42 U.S.C. § 1396c. The Medicaid statute requires participating States to "provide for procedures of prepayment and post-payment claims review." 42 U.S.C. § 1396a(a)(37)(B).

Oregon's Medicaid plan sets up a two-tier system for reimbursing health care facilities ("providers") such as

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[2] The other parties before the Court are Richard Ladd, Administrator of the DHR division directly administering Oregon's Medicaid program; Hannah Schwanke ("Schwanke"), guardian *ad litem* of David and Steven Schwanke; and Sandy Mauer ("Mauer"), guardian *ad litem* of Tami Mauer. David and Steven Schwanke and Tami Mauer are residents at Coos Bay.

Coos Bay. At level one, pursuant to Or. Admin. R. 411-70-085(1), providers that choose to participate in Oregon's Medicaid program are reimbursed for "all services, supplies, and facility equipment required for care," so long as the providers' claimed costs fall within "the [lower] 75th percentile ranking" of all eligible facilities in terms of costs ("the established rate"). Or. Admin. R. 411-70-440.[3] At level two, an additional "heavy cost" reimbursement rate is available for the care of a narrowly defined class of patients: functional quadriplegics "ready for discharge from an acute care hospital or whose care could be provided in a nursing facility in lieu of placement in an acute care hospital." Or. Admin. R. 411-70-030(1)(b).

The instant litigation arises out of a contract entered into by Coos Bay and DHR in the spring of 1982.[4] Under the agreement, Coos Bay was to provide health care services to persons qualifying for Medicaid assistance in return for reimbursement by DHR pursuant to Oregon's Medicaid plan. An addendum to the contract entitled Coos Bay to additional compensation for the care of persons certified by DHR as eligible for "heavy cost care." DHR concluded that the respondent residents of Coos Bay did not qualify as "heavy cost care" patients, that the addendum to the contract was therefore inapplicable, and that Coos Bay was entitled only to the established rate of reimbursement.

Respondents disagreed and brought suit *directly* in federal district court under, *inter alia*, 42 U.S.C. § 1983,

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[3] That is, if a facility's claimed costs fall within the lower 75% of those incurred by all facilities, Oregon reimburses the facility for all its costs. If the claimed costs are greater than those incurred by facilities within the lower 75th percentile, Oregon reimburses the facility at the 75th percentile rate and no more.

[4] Pursuant to federal requirements, 42 U.S.C. § 1396a(a)(27), health care facilities like Coos Bay agree to participate in the Oregon Medicaid program by entering into a "provider contract" with DHR. That contract binds the intermediate care facility to the applicable Oregon statutes and administrative rules.

seeking damages, injunctive and declaratory relief, and certification as a class action. In so doing, respondents bypassed the state rate reimbursement review procedures established by Oregon in accordance with Congress' command. 42 U.S.C. § 1396a(a)(37)(B). Specifically, rate reimbursement disputes are to be resolved by an impartial administrative decisionmaker after a hearing in which the provider may introduce all pertinent evidence. Or. Admin. R. 461-09-000. A provider dissatisfied with the administrative hearing officer's decision may appeal that determination to the Oregon Court of Appeals. Or. Rev. Stat. §§ 183.482, 183.484. Respondents failed to avail themselves of this review process.

Respondents do not complain that Oregon's Medicaid plan itself violates federal law. Rather, respondents' essential contention is that, under the provider contract and applicable state regulations, Coos Bay is entitled to more money for its care of certain Medicaid patients who ought to qualify for "heavy cost care." The individual respondents complain that the failure to reimburse Coos Bay at the "heavy cost care" level deprives them of the full range of appropriate care, but they allege no specific injury.

The case was assigned to a United States Magistrate for findings and recommendations. Ruling on petitioners' motion to dismiss for failure to state a claim on which relief could be granted, the magistrate concluded that, under the facts alleged, 42 U.S.C. § 1396a *et seq.* did not create enforceable rights or a private right of action and that respondents therefore could not sue under 42 U.S.C. § 1983. The United States District Court for the District of Oregon adopted these findings and dismissed respondents' complaint with prejudice and without leave to amend.

The United States Court of Appeals for the Ninth Circuit reversed, holding that respondents' complaint did

state a claim cognizable under Section 1983. The court of appeals reasoned that: (1) under *Maine v. Thiboutot*, 448 U.S. 1 (1980), all actions based on violations of the Social Security Act, of which Medicaid is a part, are cognizable through Section 1983 actions; and (2) even if analyzed under the test enunciated most recently in *Wright v. City of Roanoke Redevelopment & Housing Authority*, —— U.S. ——, 107 S.Ct. 766 (1987), (a) respondents had a right for purposes of Section 1983 because they were among the class especially intended to be benefitted by Medicaid, and (b) the state administrative remedy that Congress "permitted" the States to offer for violations of that right was not sufficiently comprehensive to indicate congressional intent to preclude resort to Section 1983 actions. *Coos Bay Care Center v. Oregon Dept. of Human Resources*, 803 F.2d 1060, 1062-63 (9th Cir. 1986) (*"Coos Bay"*).

SUMMARY OF ARGUMENT

I. Title 42 U.S.C. § 1983 provides a remedy only for the deprivation of a right, privilege, or immunity secured by the Constitution or by federal law, and only when Congress has not indicated an intent to foreclose such a remedy.

The complaint in this case alleges a violation only of state law. Respondents rely on a regulation of the Oregon Department of Human Resources, claiming that its inclusion in the State's Medicaid plan gives it the force and effect of a federal law for purposes of Section 1983. This novel theory finds no support in the language of the Medicaid statute, its legislative history, judicial precedent, or federal agency interpretations.

Medicaid is a federal-state cooperative endeavor to provide medical services for the needy. The federal law itself establishes no entitlement to any particular level of patient care reimbursement. It permits each participating State to develop its own plan and reimbursement rates; amendments to the original law have granted to the States progressively wider discretion in determin-

ing rate-setting methodology. To treat the elements of an individual State's plan as federal law would undermine the scheme of federal-state cooperation under Medicaid and under numerous other federal grant programs that establish a similar role for States. Section 1983 actions would become a commonplace to challenge alleged departures by the States from their own regulations.

Respondents' assertion of a federal right to "reasonable and adequate" reimbursement under the Medicaid statute finds no support in the language of the federal law. The statute requires only that a state plan provide for reasonable and adequate reimbursement. By not setting any particular reimbursement rate, the statute discloses a systemic focus rather than an intent to create individual rights. Moreover, extensive state liability should not be inferred from the requirement that participating States provide "assurances" satisfactory to the Secretary of HHS.

The court below erroneously concluded that respondents had a right under Section 1983 on the ground that they were among the intended beneficiaries of the Medicaid program. Decisions of this Court have made it clear that an intended benefit is not sufficient to create an enforceable right. Moreover, providers like Coos Bay are not among the intended beneficiaries of Medicaid. Respondents' argument that the "reasonable and adequate" reimbursement standard in the Medicaid statute, independent of Oregon's plan, requires that they receive payment for "heavy cost care" would nullify the carefully crafted scheme for state administration of the Medicaid system in accordance with state plans and would turn the federal courts into glorified Medicaid claims adjusters.

Even if respondents derived some right from the Medicaid law, the comprehensive remedies set forth in that statute indicate that Congress intended to foreclose its enforcement under Section 1983. These remedies include initial review of state plans by HHS before they

are approved; ongoing federal review and supervision of state plan administration; the authority given to HHS to cut off funding, either in whole or in part; and the statutory requirement that the States provide both prepayment and postpayment administrative review procedures. The expressed congressional preference for claims review at the state level precludes initial recourse to a Section 1983 remedy.

II. Assuming, *arguendo*, that the Medicaid statute could be read to confer on respondents an enforceable right to "heavy cost care" reimbursement, Section 1983 does not afford them a remedy at this stage. Until they have invoked the administrative remedy mandated by Congress, there has been no final denial of any such right. The State's action is neither final nor complete, because respondents have failed to invoke the administrative review which might have resulted in action favorable to them. The very statute on which respondents rely requires utilization of the state hearing mechanisms that respondents have bypassed. Respondent Coos Bay, moreover, in its contract with DHR, bound itself to the procedures provided by the State for protection of its rights.

Finally, even if respondents' failure to invoke the congressionally mandated administrative review procedure does not absolutely bar them from pursuing a remedy under Section 1983, the federal courts, out of deference to congressional intent and considerations of comity, should abstain from deciding whether the State's regulation applies to these respondents.

ARGUMENT

I. RESPONDENTS CANNOT STATE A CLAIM UNDER 42 U.S.C. § 1983 FOR PETITIONERS' FAILURE TO REIMBURSE THEM AT OREGON'S "HEAVY COST CARE" RATE.

A cognizable claim under 42 U.S.C. § 1983 has three distinct predicates. The claim must (1) arise out of the deprivation of an enforceable *right* (*see Pennhurst State*

School and Hospital v. Halderman, 451 U.S. 1, 22 (1981) (*"Pennhurst I"*)), (2) that is secured by *federal* law (*see Martinez v. California*, 444 U.S. 277, 285 (1980)), (3) for which Congress has not provided a comprehensive remedy (*see Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1, 20-21 (1981) (*"Sea Clammers"*)). Because respondents have not satisfied even one of these requirements, their action is not cognizable under Section 1983.

A. The Right Asserted By Respondents Arises From State Law, Not Federal Law.

Violations of state law do not give rise to actions under 42 U.S.C. § 1983. *See Paul v. Davis*, 424 U.S. 693, 694, 699-702 (1976). Section 1983 affords relief only to a plaintiff deprived of a right, privilege, or immunity secured by the Constitution or *federal* law. *See Martinez v. California*, 444 U.S. at 285. That predicate is lacking in this case.

Respondents filed suit seeking "more money for services rendered to certain persons eligible for state and federal medical assistance." Magistrate's Findings and Recommendations, Pet. App. 10. Their complaint does not allege that Oregon's Medicaid program itself violates the requirement of federal law that plans provide reimbursement at levels "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). Instead, respondents ground their claim on alleged violations of Or. Admin. R. 411-70-030 and Coos Bay's contract with DHR.[5] Respondents' claim under Section 1983, therefore, depends on the proposition that state plans and regulations enacted pursuant to federal statutes are federal laws for purposes of Section 1983.

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[5] This fact, among others, serves to distinguish the case at hand from *Maine v. Thiboutot*, 448 U.S. 1 (1980), where the Section 1983 action was based directly on the state agency's failure to comply with *federal* requirements under 42 U.S.C. § 602(a)(7) and not, as here, a *state* regulation that, in turn, is allegedly required by federal law.

Amici respectfully submit that the law, as well as common sense, is to the contrary.[6] Respondents' position that Oregon's Medicaid regulations are federal law for purposes of Section 1983 is inconsistent with the language and framework of the Medicaid statute; its legislative history, particularly the trend toward greater state discretion; and the interpretation of the relevant federal agency.

Medicaid is a federal-state "cooperative endeavor." *Harris v. McRae*, 448 U.S. 297, 308 (1980). The federal government approves plans submitted by each State for funding medical services to the poor and subsidizes a significant portion of the costs incurred by the States, but each State administers the program in conformity with its own plan. *See Alexander v. Choate*, 469 U.S. at 289 n.1. Originally, the States had no choice but to reimburse facilities like Coos Bay according to the cost methodology used by the federal government in administering Medicare. But in 1972, concerned about escalating costs, Congress adopted the "reasonable cost related standard" for reimbursement, thereby allowing States to make their own reimbursement decisions and giving them flexibility in achieving satisfactory payment arrangements with health care facilities. H.R. Rep. No. 231, 92d Cong., 1st Sess. 101 (1971).[7]

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[6] Even if the Court should conclude that respondents' claim alleges a violation of federal law, respondents are foreclosed from bringing a Section 1983 suit because they lack a right and because comprehensive remedies exist. See Part I.B., *infra*.

[7] As the court discussed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972) . . . . Additionally, Congress intended

In 1980, by the Boren Amendment, Congress instituted the current requirement that state plans provide reimbursement rates "(determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). The Boren Amendment establishes two crucial points. First, the Amendment expanded, yet again, the States' discretion in developing and implementing reimbursement methodologies.[8] The Health Care Financing Administration ("HCFA")[9] has acknowledged the "*legislatively mandated* flexibility" that the statute provides to the States in determining reimbursement rates. 48 Fed. Reg. 56049 (1983) (emphasis added).

Second, Congress clearly indicated its intent that reimbursement rates were to be determined in accordance with *state*, not federal, methods and standards. HCFA has specifically declined to issue more "explicit criteria for Federal review of States' methods and standards for establishing payment rates" lest "such a list of criteria

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that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

[8] The legislative history behind the 1981 amendment extending the Boren Amendment to hospitals as well as other long-term care facilities indicates that

> [i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States *greater latitude* in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981) (emphasis added).

[9] HCFA, an agency of HHS, must approve reimbursement rates set by state Medicaid plans. Its opinion is entitled to a measure of deference. *See Schweiker v. Hogan*, 457 U.S. 569, 588 (1982) (quoting *Blum v. Bacon*, 457 U.S. 132, 141 (1982)).

. . . be viewed as imposing Federal standards for payment rates, an effect that would be contrary to the legislative intent." 48 Fed. Reg. 56050 (1983). Thus, even if providers have a right to "reasonable and adequate" reimbursement,[10] the contours of that "right" are plainly defined by state, not federal, law.

The United States Court of Appeals for the Second Circuit has recently rejected an argument, like respondents', that provisions of state Medicaid plans confer rights under federal law. In *Oberlander v. Perales*, 740 F.2d 116 (2d Cir. 1984), a health care facility participating in Medicaid brought a Section 1983 action alleging that the State of New York had violated its own regulation in reducing the rate of reimbursement for providers. The provider argued that, because the regulation was required to conform with 42 U.S.C. § 1396a *et seq.*, a violation of the regulation was, *ipso facto*, a violation of the federal statute. The court of appeals held (*id.* at 119) (citations omitted):

> We reject this tortuous argument, which, if valid, would provide a jurisdictional basis for federal judicial review of every disputed state administrative ruling relating to Medicaid. "[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States," *Maine v. Thiboutot*, 448 U.S. 1, 4 . . . (1980) (quoting *Edelman v. Jordan*, 415 U.S. 651, 675 . . . (1974)), but there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law.

Oberlander reached the only sensible conclusion. A holding by this Court that a state Medicaid regulation becomes a federal law simply by virtue of its inclusion

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[10] Part I.B.1., *infra*, addresses Coos Bay's claim that it has a right to reimbursement at the "heavy cost care" rate because of the requirement that States provide "reasonable and adequate" reimbursement. 42 U.S.C. § 1396a(a)(13)(A).

in a state plan contemplated by federal law would have drastic practical consequences. The structure of the Medicaid statute is very common. Numerous federal-state cooperative endeavors provide federal funds to the States for programs that are contained in state plans approved by a federal agency.[11] Federal courts would be inundated with Section 1983 claims brought by businesses and individuals participating in other federally funded programs with complaints about the States' implementation of their own regulations.

Liability under Section 1983 would be particularly inequitable in cases such as this where the state regulations at issue almost certainly are not required by the Medicaid statute.[12] Oregon's "heavy cost care" component is paid in addition to the established rate approved by the Secretary of HHS as the rate that will reimburse efficiently operated facilities for services provided to Medicaid patients. No other state Medicaid plan contains a "heavy cost care" provision; and only ten other States have provisions for any supplemental reimbursement.[13]

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[11] See, *e.g.*, 7 U.S.C. § 2020(d) (Food Stamp program); 16 U.S.C. § 460*l*-8(d) (Land and Water Conservation Fund program); 20 U.S.C. § 1205(b) (Adult Education program); 20 U.S.C. § 1413 (Education of the Handicapped program); 42 U.S.C. § 654 (Child Support Enforcement program); 42 U.S.C. § 1786(f) (Special Supplemental Food Program for Women, Infants and Children); 42 U.S.C. § 9904(d) (Community Services Block Grant program).

[12] An interpretation of Section 1983 that might force the States to limit their exposure to liability by providing low benefits and minimal protections for Medicaid recipients should obviously be avoided.

[13] California provides special rates for the mentally disordered and the developmentally disabled. In Florida, the class ceiling may be waived in "very unusual and costly circumstances." In Illinois, higher rates may be negotiated for recipients "requiring exceptional care." Kentucky and Maryland have special rates for hospital-based facilities. Michigan has a special rate for facilities serving ventilator-dependent patients, and permits an individually negotiated rate for patients transferred to an SNF (skilled nursing

The "heavy cost care" rate, like other innovative and diverse Medicaid programs, is purely a matter of state law.[14] Congress did not intend "cooperative federalism" [15] to become federal co-option.

B. Respondents' Allegations Concerning Federal Law Do Not Establish A Right Enforceable Under Section 1983.

The complaint summarizes various provisions of the Medicaid statute and regulations. These references apparently led the court of appeals to infer an allegation that the reimbursement afforded Coos Bay was inadequate and therefore in violation of federal law (and not merely state regulations). Such an allegation, even if properly discerned in respondents' complaint, would not support an action under Section 1983.

According to this Court's most recent pronouncement, there are "two exceptions to the application of § 1983 to

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facility) from acute care to receive specialized and concentrated nursing and support services. Rate reimbursement in Nebraska takes account of the additional cost of caring for ventilator-dependent recipients. New Jersey has a special provision for the mentally retarded. Utah provides "reimbursement incentives" to nursing homes admitting patients from hospitals with special care needs that cannot be provided under existing SNF rates, and permits negotiation of special rates for patients requiring more care than can be provided under basic SNF rates. Virginia provides retroactive reimbursement under Medicare principles to institutions for mental diseases that provide SNF and ICF (intermediate care facility) care to individuals 65 or older, and to ICFs for the mentally retarded. Thirty-eight States and the District of Columbia have no special provisions for nursing home reimbursement based on patient classification. Arizona's plan provides no reimbursement at all for nursing home services. See generally 3 Medicare and Medicaid Guide (CCH) ¶¶ 15,550-15,660.

[14] Thus, in addition to its deficiencies in stating a cause of action under Section 1983, respondents' complaint raises serious Eleventh Amendment questions. *See Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89 (1984) (*"Pennhurst II"*).

[15] *Harris v. McRae*, 448 U.S. 297, 308 (1980) (describing the Medicaid program).

remedy statutory violations: where Congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges or immunities within the meaning of § 1983." *Wright v. City of Roanoke Redevelopment & Housing Authority*, 107 S.Ct. at 770-71 (discussing *Smith v. Robinson*, 468 U.S. 992 (1984); *Sea Clammers*, 453 U.S. 1 (1981); and *Pennhurst I*, 451 U.S. 1 (1981)).[16] We address these exceptions in reverse order.

1. *Respondents' interest in reimbursement at the "heavy cost care" rate does not rise to the level of an enforceable right.*

Respondents appear to argue that a right to "reasonable and adequate" reimbursement inheres in 42 U.S.C. § 1396a(a)(13)(A). This interpretation comports with neither the plain language nor the fair meaning of the statute.

In determining whether a statute creates enforceable rights, the "key to the inquiry is the intent of the Legislature." *See Sea Clammers*, 453 U.S. at 13; *Pennhurst I*, 451 U.S. at 15. The search for that intent begins with the language of the statute itself. *See Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 197 (1976) (quoting *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975) (Powell, J., concurring)). Here, the pertinent statutory language is that

> [a] *State plan* for medical assistance must . . . provide . . . for payment . . . for . . . services provided under the plan through the use of rates (deter-

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[16] The court of appeals' holding that this case is controlled by *Maine v. Thiboutot*, 448 U.S. 1 (1980), is, therefore, wrong because it ignores this Court's decisions subsequent to *Thiboutot*, none of which even suggests that the exceptions identified in those cases do not apply to alleged violations of the Social Security Act. Moreover, in *Thiboutot*, the Court was not called upon to decide *whether* a federal law (specifically, the Aid to Families with Dependent Children Act) had been violated, but only whether attorney's fees were available under 42 U.S.C. § 1988 to redress a conceded violation of a federal law other than federal civil rights legislation.

> mined in accordance with methods and standards developed by the State . . .) *which the State finds*, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

This language simply cannot be read, as respondents wish, to confer on providers a right to a particular level of reimbursement. First, the statute speaks only of a state Medicaid plan, and not of actual reimbursement for providers. In fact, federal law does not require any specific plan, but only that the State, if it wishes to participate in Medicaid, have a plan approved by the Secretary of HHS. The focus, therefore, is on the state system and not on individual recipients of benefits. *Cf. Pennhurst I*, 451 U.S. at 22 (rather than conferring individual rights, Developmentally Disabled Assistance and Bill of Rights Act has "systemic focus"). Thus, if respondents have a right under the Medicaid program, it is no more than the right to a state *plan* providing for reasonable and adequate reimbursement to health care providers generally, and not to any particular reimbursement *rate*.

Second, any alleged right accorded by § 1396a(a)(13)(A) arises from the "assurances" required to be given to the Secretary of HHS. This Court has expressed skepticism whether an individual's interest in having a State provide its "assurances" to a federal agency in order to receive government funding is a " 'right secured' by the laws of the United States within the meaning of § 1983." [17] *Pennhurst I*, 451 U.S. at 28. Far-reaching in-

[17] In fact, respondents do not claim infringement of their "right" to a state Medicaid plan providing for "reasonable and adequate" reimbursement. Their complaint does not allege that Oregon's Medicaid plan itself violates the federal statute. Rather, respondents allege that Oregon has violated Coos Bay's "right" under 42 U.S.C. § 1396a(a)(13)(A) to be reimbursed at the "heavy cost care" rate. This "right," as demonstrated above, is not provided by the statute.

dividual rights and extensive state liability should not rest on inferences drawn from such assurances. If Congress had wished to create rights on behalf of providers to a particular level of funding, it would surely have been more explicit. *See Rose v. Rose*, —— U.S. ——, 107 S. Ct. 2029, 2035 (1987); *Alexander v. Choate*, 469 U.S. at 307-08 n.32.[18]

Completely ignoring the statutory language, the court of appeals held that respondents had a right enforceable through a Section 1983 action on the ground that the statute "was enacted for the special benefit" of respondents or their class. *Coos Bay*, 803 F.2d at 1063. As the court itself recognized, its entire analytical framework consisted of but *one* of the four factors identified by this Court in *Cort v. Ash*, 422 U.S. 66 (1975), as appropriate for determining whether a federal statute creates an implied right of action. *Coos Bay*, 803 F.2d at 1063. Not only does this approach contravene the Court's directive in *Sea Clammers* and *Pennhurst I* to examine statutory intent, but it also erroneously equates rights with intended benefits. Simply because Congress intends to benefit a class of persons through a statute does not mean it intends to create for them a *right* to the benefit conferred. *See Bowen v. Gilliard*, Nos. 86-504 & 86-561 (U.S. June 25, 1987), slip op. 16-17; *Heckler v. Turner*, 470 U.S. 184, 189-90 & n.3 (1985); *Pennhurst I*, 451 U.S. at 22.

Indeed, as reflected in this Court's recent decisions, funding statutes such as Medicaid, although undoubtedly intended to benefit certain individuals, may not create rights. For example, *Pennhurst I* dealt with the Developmentally Disabled Assistance and Bill of Rights Act, 42

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[18] The absence of merit in respondents' claim that the Medicaid statute entitles Coos Bay to a particular level of reimbursement is clear from the voluntary nature of Oregon's decision to join the program. State participation in the Medicaid program is entirely optional (*see Harris v. McRae*, 448 U.S. at 301), and respondents could assert no rights under *federal* law had Oregon elected not to participate.

U.S.C. § 6000 *et seq.*, which the Court recognized was intended to benefit the developmentally disabled. *See Pennhurst I*, 451 U.S. at 11. Yet, the Court, with specific reference to Medicaid, the very statute involved in this case, stated:

> In sum, nothing suggests that Congress intended the Act to be something other than a typical funding statute. *Far from requiring the States to fund newly declared individual rights*, the Act has a systemic focus, seeking to improve care to individuals by encouraging better state planning, coordination, and demonstration projects. *Much like the Medicaid statute . . .*, the Act at issue here was "designed as a cooperative program of shared responsibilit[ies], not as a device for the Federal Government to compel a state to provide services that Congress itself is unwilling to fund."

Id. at 22 (emphasis added) (quoting *Harris v. McRae*, 448 U.S. at 309).

More recently, in *Alexander v. Choate*, the Court rejected the contention by a class of handicapped persons that they were discriminated against under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, because Tennessee's Medicaid plan imposed a limit of fourteen days of inpatient hospital care per year. Writing for a unanimous Court, Justice Marshall explained (469 U.S. at 302-03) (emphasis added):

> To the extent respondents further suggest that their greater need for prolonged inpatient care means that, to provide meaningful access to Medicaid services, Tennessee must single out the handicapped for *more* than 14 days of coverage, the suggestion is simply unsound. At base, such a suggestion must rest on the notion that the benefit provided through state Medicaid programs is the amorphous objective of "adequate health care." *But Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs.* Instead, the

benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not "adequate health care."

The federal Medicaid Act makes this point clear. *The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage,* as long as care and services are provided in "the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

Furthermore, even if the one-factor test used by the court below were appropriate, it is apparent that health care providers like Coos Bay are not among the intended beneficiaries of Medicaid. *See Geriatrics, Inc. v. Harris,* 640 F.2d 262, 265 (10th Cir.), *cert. denied,* 454 U.S. 832 (1981); *Green v. Cashman,* 605 F.2d 945, 946 (6th Cir. 1979); *see also Silver v. Baggiano,* 804 F.2d 1211, 1216 n.3 (11th Cir. 1986). As the United States Court of Appeals for the Second Circuit observed:

> That a particular nursing facility cannot survive without Medicaid participation was certainly not Congress' foremost consideration in its creation of the Medicaid program. . . . The benefits to a nursing home from its participation in Medicaid reimbursement results from nothing more than a statutory business relationship.

Case v. Weinberger, 523 F.2d 602, 607 (2d Cir. 1975) (footnote omitted). Indeed, the statutory language expressing the purpose of Medicaid appropriations is conspicuous in its failure to mention the interests of providers at all. 42 U.S.C. § 1396a. Medicaid was created to aid participating States "in funding of medical services for the needy" (*Alexander v. Choate,* 469 U.S. at 289 n.1), not for providers.[19]

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[19] Coos Bay sought to bring itself within the statute's fold by having the facility's residents, the true intended beneficiaries of

Respondents appear to argue that the denial of "heavy cost care" reimbursement deprives them of rights under federal law because they assert that 42 U.S.C. § 1396a (a) (13) (A) requires a reimbursement level that is "reasonable and adequate" and that this level is not met without the "heavy cost care" rate for certain Coos Bay residents. Significantly, this claim does not depend on the existence in the Oregon Medicaid plan of the "heavy cost care" rate. Thus, the same claim could be raised against every State, whether or not it had a "heavy cost care" rate. Were respondents' argument sufficient under Section 1983, the state plans, so carefully conceived as the linchpin of the Medicaid system, would become irrelevant. The federal courts would become glorified Medicaid claims adjusters, reviewing countless highly technical, individual reimbursement decisions. Not only would the case load swamp the federal courts, but the sure guidance furnished to States, recipients, and providers by written state Medicaid plans would give way to the vagaries of case-by-case adjudication.[20] The right urged by respond-

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Medicaid, join its complaint. This procedural ploy is exposed by: (1) the relief sought in the complaint, which was an increase in reimbursement rates for Coos Bay, not respondents Mauer and Schwanke; and (2) the absence of allegations by the individual respondents that they have been denied any direct payment due them or that they have been specifically injured. *Cf. Maine v. Thiboutot*, 448 U.S. 1 (1980) (complaint that State's failure to make allowance for cost of supporting children by current marriage in calculating benefits violated Aid to Families with Dependent Children statute). Moreover, the court of appeals was incorrect in its assertion that the interests of the classes of respondents are parallel. The only concern of residents at Coos Bay is to maximize their own health care. Coos Bay, on the other hand, as a for-profit corporation, presumably aims to maximize its profits. In short, a provider is not an intended beneficiary of Medicaid and does not become one simply by joining recipients as co-plaintiffs.

[20] The central role intended for state Medicaid plans is evidenced by the statute's framework. The detailed requirements found throughout the statute are all phrased in terms of what a state plan must provide. See 42 U.S.C. § 1396a *et seq.*; *see also Alexander v. Choate*, 469 U.S. at 289 n.1.

ents and accepted by the court below must be seen for what it is: a license to contest in federal court under Section 1983 every reimbursement term in a provider contract and every reimbursement rate decision made by a state Medicaid agency.

2. *Congress provided comprehensive remedies under the Medicaid statute in order to foreclose direct action under Section 1983.*

This Court has held that "[w]hen the remedial devices provided in a particular Act are sufficiently comprehensive, they may suffice to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. The critical consideration, again, is what Congress intended. *See Smith v. Robinson*, 468 U.S. at 1012-13.

The analysis must begin by defining the "right" to be protected by the remedies under examination. As we demonstrate in Part I.B.1, *supra*, the only right that respondents arguably have under the Medicaid program is a right to a state Medicaid plan that provides for reasonable and adequate reimbursement to health care providers, if the State participates in Medicaid. Respondents do not allege, and they could not prove, a deprivation of that right; Oregon has a state plan, and it has been approved by the Secretary of HHS. Even if the Medicaid statute could be read to create a right to reasonable and adequate reimbursement for providers (and not simply a plan to that effect), the remedies afforded for violations of that right are sufficiently comprehensive to foreclose recourse to Section 1983.

At the primary level, a state plan not complying with the Medicaid statute will fail to win the approval of the Secretary of HHS. 45 C.F.R. § 201.3(d) (1986). The plan must be a "comprehensively" written document (42 C.F.R. § 447.252(b) (1986)) that, among other things, "allow[s] interested parties an understanding of the ratesetting process and the items and services that are paid for through those rates." Department of

Health and Human Services, Health Care Financing Administration, State Medicaid Manual, 6-4 (April 1984).

Once approved, the plan is subject to continued scrutiny by the Secretary of HHS to ensure that federal requirements are satisfied. *See Charleston Memorial Hospital v. Conrad*, 693 F.2d 324, 327 (4th Cir. 1982). The Department of HHS, through its Audit Agency, conducts audits, annually or as appropriate, of the state Medicaid agency's operations. 45 C.F.R. § 201.12 (1986). The Social and Rehabilitation Service of HHS is authorized to conduct a review to ensure that the State is complying with federal substantive requirements. 45 C.F.R. § 201.10 (1986). State Medicaid agencies must, under 42 C.F.R. §§ 431.17, 431.18(f) (1986), maintain records and make program policy materials available to providers who request them. 48 Fed. Reg. 56051 (1983). If the Secretary of HHS determines that the State is improperly implementing its plan or not following a new federal requirement, he may either completely cut off federal funding (42 U.S.C. § 1396c; 45 C.F.R. § 201.6 (1986)), or "in his discretion," limit payments to "categories under or parts of the state plan not affected by such failure." 42 U.S.C. § 1396c.[21] In the matter at hand, the Secretary would have the option of terminating federal funds for only the portion of Oregon's Medicaid plan relating to "heavy cost care" patients.

The Medicaid statute provides the additional remedy of prepayment and postpayment claims review procedures at the state level. The court of appeals denigrated this remedy, believing that the review procedures were an optional feature of a state Medicaid plan. *See Coos Bay*,

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[21] This cut-off threat alone may constitute a sufficiently comprehensive remedy to foreclose recourse to Section 1983. For legislation such as Medicaid, enacted pursuant to the spending power, "the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but an action by the Federal Government to terminate funds to the States." *Pennhurst I*, 451 U.S. at 28.

803 F.2d at 1062 ("Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements.") (emphasis added). The court was in error. States are *required* to provide for review of disputed reimbursement decisions (42 U.S.C. § 1396a(a)(37)(B)); and a State must provide written assurances that this "essential" element of its reimbursement plan is met. 48 Fed. Reg. 56056 (1983). The review must take the form of "an appeals or exception procedure that allows individual providers an opportunity to submit *additional* evidence and receive *prompt* administrative review." 42 C.F.R. § 447.253(c) (1986) (emphasis added). Thus state administrative review must be both comprehensive and quick.

HCFA has found the claims review procedures of the Oregon Medicaid plan fully satisfactory, and respondents do not even allege that these procedures are in any way deficient. By administrative rule, health care providers and facility patients may contest DHR reimbursement and benefit decisions, and receive administrative review where, with the assistance of counsel, they may present all pertinent facts and evidence. Or. Admin. R. 461-09-000(3). If dissatisfied with the decision of the impartial administrative hearings official, providers or patients may obtain judicial review in state court under the Oregon Administrative Procedures Act, Or. Rev. Stat. §§ 183.482, 183.484. Thus, administrative and judicial review of both state benefit and reimbursement decisions were available to respondents as a matter of right. HCFA has recognized that implicit in this and other state claims review procedures are "fair and reasonable rate adjustments." 48 Fed. Reg. 56052 (1983).

Permitting a Section 1983 action would disrupt this comprehensive remedial scheme by moving the forum for rate reimbursement challenges from the States, where they belong, to the federal courthouse, where they do not. *Amici* submit that Medicaid reimbursement decisions, based as they are on extensive technical data, simply are

not conducive to efficient review by federal courts.[22] By contrast, administrative appeals procedures tailored to local conditions are designed to make precisely the sort of prompt, highly factual determinations inherent in rate reimbursement review.

If the judgment below is affirmed, it is readily foreseeable that a large number of providers dissatisfied with reimbursement rates will follow the path of Coos Bay to the perceived haven of the federal district court—particularly with the vision of 42 U.S.C. § 1988 attorney's fees ahead. The resulting burden on limited state resources and crowded federal dockets would be further compounded by the fact that rate reimbursement decisions are not one-time events. This Court has refused to assume that Congress intended to condition federal funds upon the States' incurring the enormous obligation of defending Section 1983 suits. *See Pennhurst I*, 451 U.S. at 24-25. This principle has special applicability where, as here, Congress has specified the remedy that the States must provide for rate reimbursement challenges and States such as Oregon have expended funds to meet this requirement. *See Tennessee Valley Authority v. Hill*, 437 U.S. 153, 188 (1978) (applying maxim of *expressio unius est exclusio alterius*).

Obviously, respondents, like the plaintiffs in *Smith v. Robinson* and *Sea Clammers*, would prefer to bring a Section 1983 action to remedy alleged violations of a federal statute and regulations rather than to seek relief through the review procedures required by the federal

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[22] *Maine v. Thiboutot*, 448 U.S. 1 (1980), stands in sharp contrast. In that case, the issue was whether, in computing Aid to Families with Dependent Children benefits (to which a father was entitled for his three children by a previous marriage), allowance should be made for money spent to support his five children by a current marriage. The claim was based on specific provisions of the federal statute and was a purely legal dispute, not requiring the technical, factual expertise demanded by Medicaid rate reimbursement challenges. Moreover, the claimant had pursued the State's administrative remedies and judicial review procedures.

statute. The determinative inquiry, however, is not the wishes of the plaintiff but the intention of Congress. *See Smith v. Robinson*, 468 U.S. at 1012 ("The crucial consideration is what Congress intended."). And clearly, Congress intended to foreclose Section 1983 actions for disputed rate reimbursement decisions.

II. RESPONDENTS' CLAIM IS NOT RIPE FOR RESOLUTION BY A FEDERAL COURT UNDER SECTION 1983 BECAUSE THEY HAVE NOT AVAILED THEMSELVES OF THE PROCEDURAL REVIEW MECHANISM MANDATED BY FEDERAL AND STATE LAW.

Even if Section 1983 actions were not foreclosed for disputes over rate reimbursement under Medicaid, respondents' action would be premature in light of Congress' intent that claims review occur at the state level, as well as settled judicial doctrines, such as finality and abstention, that preclude federal review at this time.

This case involves a disagreement between a state Medicaid agency and a Medicaid provider over the appropriate level of reimbursement for certain Medicaid recipients. Foreseeing the inevitability of such disputes, Congress ordained a remedy: States are required to establish procedures affording dissatisfied providers a right to appeal reimbursement decisions, thus ensuring quick claims review at the state level. 42 U.S.C. § 1396a(a)(37)(B). Consistent with the congressional command, HCFA will approve state Medicaid plans only if they contain procedures that implement Congress' goal of prompt and meaningful review. 42 C.F.R. § 447.253(c) (1986). HFCA considers this review process one of "the essential elements of a State's reimbursement system" and a prerequisite for judicial review. 48 Fed. Reg. 56056, 56052 (1983). In fact, HFCA declined to issue more specific regulations regarding the criteria for appropriate "assurances" that reimbursement rates are reason-

able and adequate, in part because of the availability of provider appeals. 48 Fed. Reg. 56050 (1983).

As this case illustrates, state administrative procedures cannot compete with the lure of the federal courts. A decision of this Court authorizing dissatisfied providers to proceed directly into federal court would render the state administrative procedures superfluous and 42 U.S.C. § 1396a(a)(37)(B) meaningless. *See Smith v. Robinson*, 468 U.S. at 1012 (precluding Section 1983 action for violation of the Education of the Handicapped Act in part because such a result would render provisions in the statute superfluous). More important, such a result would frustrate Congress' objective of ensuring timely administrative review.

In the closely related context of Medicare reimbursement, this Court recently held that, in light of Congress' intent that administrative procedures be used, the dissatisfied program participants before the Court had to avail themselves of their administrative remedies before proceeding to federal court. *See Heckler v. Ringer*, 466 U.S. 602 (1984). In deferring to Congress, the Court explained, in words fully applicable to Medicaid reimbursement (*id.* at 627) (footnote omitted):

> Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this Court.

The policy rationale for preventing respondents from bypassing state procedural structures flows from the system of "cooperative federalism" of which Medicaid is a part. *See Harris v. McRae*, 448 U.S. at 308 (1980) (quoting *King v. Smith*, 392 U.S. 309, 316 (1968)). Pursuant to 42 U.S.C. § 1396a(a)(37)(B), Congress placed the responsibility for reviewing reimbursement

decisions upon the States because they are best able to determine a scheme of rates. Through the technical expertise of administrative tribunals and their knowledge of local conditions and concerns, States are particularly suited to provide the type of fast, efficient review that serves the interests of providers as well as state Medicaid agencies. Rate reimbursement disagreements may be more cheaply resolved at the state level before they become expensive Section 1983 lawsuits. Moreover, because the State-provider relationship is ongoing, interests of long-term stability require a less contentious forum than the adversarial arena of a federal district court. Finally, federal court litigation would compound the States' costs, for the States would remain obligated to fund the administrative review process. In short, authorization of Section 1983 actions would produce a costly, duplicative system of disputes resolution.

Reinforcing these policy considerations, as well as Congress' intent that rate reimbursement challenges be reviewed initially in the state forum, are several doctrines developed by this Court to avoid premature resolution of issues like those presented in this action.

One such doctrine is finality, both procedural and substantive. In the recent case of *Williamson County Regional Planning Comm'n v. Hamilton Bank*, 473 U.S. 172 (1985), the Court declined to review an action brought under 42 U.S.C. § 1983 alleging that a zoning Commission had taken the property of a developer without just compensation. The Commission had refused to approve a plat that conflicted with a zoning ordinance and subdivision regulations. Noting that the developer had not applied for any variances, the Court held that "the Commission's denial of approval does not conclusively determine whether [the developer] will be denied all reasonable beneficial use of its property, and therefore is not a final, reviewable decision." *Id.* at 194. *Williamson County* also held that the challenged state action was not "complete," with respect to the developer's

claim for taking without just compensation, until it had utilized the inverse condemnation remedies available under state law. *Id.* at 194-97.

Procedural finality and completeness are similarly lacking in this case because the reimbursement rate set by DHR does not conclusively determine the amount that Oregon will pay to Coos Bay for the care of the individual respondents. Like the developers in *Williamson County*, respondents abandoned the rate review process in midstream. The administrative decisionmaker may have determined that DHR was wrong, and Coos Bay right, in its interpretations of Oregon's Medicaid plan and regulations. Indeed, had Coos Bay utilized the review procedures as intended by Congress, petitioners, respondents, and three federal courts may have been spared the toll of lengthy litigation.[23] Whether defined as the entitlement to "reasonable and adequate" reimbursement under 42 U.S.C. § 1396a(a)(13)(A) or the right to "heavy cost care" under Oregon's own Medicaid regulations, respondents' right presupposes a reimbursement review process. Until that review occurs, Oregon cannot be said to have violated respondents' rights.[24]

The doctrine of abstention provides another basis for declining to review this action in its present procedural

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[23] *See FTC v. Standard Oil Co. of California*, 449 U.S. 232, 244 n.11 (1980) ("one of the principal reasons to await the termination of agency proceedings is 'to obviate all occasion for judicial review'") (quoting *McGee v. United States*, 402 U.S. 479, 484 (1971)).

[24] Respondents' reliance on *Patsy v. Florida Board of Regents*, 457 U.S. 496 (1982), is mistaken. *Patsy* addressed the issue whether 42 U.S.C. § 1983 itself required exhaustion of administrative remedies available under Florida law for claims alleging discrimination based on race and sex. The Court held that Section 1983 did not. The Court did not concern itself with whether an underlying federal statute required the use of state procedures, as is the situation here. Nor, as subsequent cases have revealed, does *Patsy* affect the applicability of doctrines other than exhaustion, *e.g.*, finality. *See Williamson County*, 473 U.S. at 194-97.

posture. Relying on *Younger v. Harris*, 401 U.S. 37 (1971), and its progeny, this Court has recently held that federal courts should abstain from adjudicating a Section 1983 action where: (1) the dispute concerns an important state interest; and (2) the state administrative proceedings are judicial in nature and provide the plaintiff a full and fair opportunity to air its federal claims. *See Ohio Civil Rights Comm'n v. Dayton Christian Schools*, —— U.S. ——, 106 S. Ct. 2718, 2723-24 (1986). The abstention doctrine applies to this case as well. Oregon clearly has a large stake in ensuring the adequate and efficient health care of its needy citizens; it participates in the Medicaid program to that precise end. Moreover, the Oregon plan's provision for a hearing before an impartial hearings official (Or. Admin. R. 461-09-000(3)), who is required to take prompt action (Or. Admin. R. 461-09-010(6)), and whose decision is subject to judicial review (Or. Rev. Stat. § 183.482), permits providers a full opportunity to present any "rights" that they might have under federal law.[25]

Bypass of the state administrative procedures is especially unfair given the factual and legal background of respondents' complaint. Coos Bay elected to do business with Oregon pursuant to its Medicaid program; indeed, it signed a contract agreeing to abide by the terms of

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[25] The procedures *mandated* by Congress for determining rate reimbursement constitute a *process* extending from the initial determination by the state Medicaid agency through review by a state administrative or judicial decisionmaker. 42 U.S.C. § 1396a(a)(37)(B) (prepayment *and* postpayment review required). Consequently, the Oregon Medicaid program, in which Coos Bay chose to participate, sets forth a two-step process for reimbursement decisions: preliminary determinations by DHR *and* review by an administrative hearings official. Or. Admin. R. 411-70-030, 411-70-440, 461-09-000 (3). Coos Bay may not escape the effect of *Younger* simply by choosing to abandon this scheme after DHR issued its decision denying Coos Bay "heavy cost care" reimbursement and before the process was complete. *Cf. Huffman v. Pursue, Ltd.*, 420 U.S. 592 (1975) (applying *Younger* where state trial court had issued injunction, but no appeal was taken, and no action was "pending").

the plan. Yet, as soon as DHR rejected its claim for "heavy cost care" reimbursement, Coos Bay chose to sever its participation with respect to state administrative procedures—the very mechanism for redressing Coos Bay's alleged injuries.

In any event, respondents' legal theory is selectively crafted simply for litigation purposes. To support their cause of action under Section 1983, respondents were required to establish a deprivation of a judicially enforceable federal right. They attempted to deduce such a right from the requirement in 42 U.S.C. § 1396a(a)(13)(A) that a state Medicaid plan provide for "reasonable and adequate" reimbursement. They chose, however, to ignore the procedure mandated in the same statute for state administrative review of provider appeals. 42 U.S.C. § 1396a(a)(37)(B). Clearly, if there is any "right" under the federal law to funding for medical costs, it is a right enforceable through the state forum provided by the same law. Thus, respondents are not properly before this Court because they have not availed themselves of the procedural review mechanisms required by federal and state law.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES

October Term 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

Brief of the States of Arizona (through the Arizona Health Care Cost Containment System), Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands as Amici Curiae in Support of Petitioners

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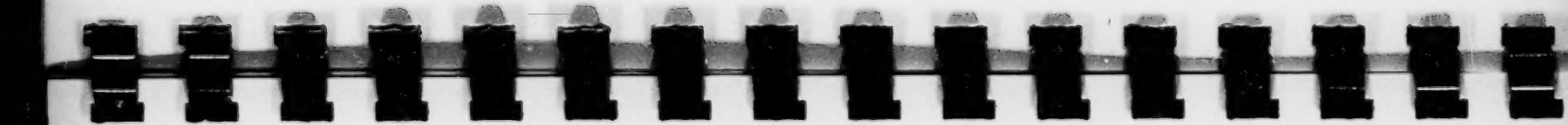

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No. 86-1419

IN THE
SUPREME COURT OF THE UNITED STATES

October Term 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

Brief of the States of Arizona (through the Arizona Health Care Cost Containment System), Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands as Amici Curiae in Support of Petitioners

Pursuant to Rule 36.4 of the Rules of this Court, the States of Arkansas, Arizona (through the Arizona Health Care Cost Containment System), California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands respectfully submit this brief as amici curiae. The amici support the effort of the petitioner State of Oregon Department of Human Resources ("Oregon") to obtain reversal of the decision of the Court of Appeals for the Ninth Circuit (803 F.2d 1060 (1986)). The Court of Appeals reversed the order of dismissal entered by

the District Court and remanded this matter for trial, holding that respondents had stated a claim cognizable under 42 U.S.C. § 1983.

STATEMENT OF INTEREST

Each of the amici participates (or expects to participate[1/]) in the Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396s. Pursuant to that program, the amici provide medical assistance to eligible needy citizens who are unable to provide for their medical care from their own resources.

As required by federal law, the Medicaid programs of each of the amici

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1/ The Northern Mariana Islands has applied to participate in the Medicaid program. Although The Northern Mariana Islands is not a State but a U.S. Territory, we use the term "State" in this brief to include it as well.

States encompass institutional medical care, including care in inpatient hospitals, skilled nursing facilities, and intermediate care facilities (hereinafter referred to as institutional "providers").2/ Medical care provided in these institutional settings comprises a major element of the Medicaid programs of the amici states, as is the case in most states throughout the nation.

Annually, if not more frequently, the amici establish Medicaid reimbursement rates for thousands of institutional

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2/ Skilled nursing facilities provide services to individuals who need, on a daily basis, care provided or supervised by skilled nursing personnel. 42 U.S.C. § 1396d(f). Intermediate care facilities provide services to individuals who do not require the degree of care and treatment provided by a skilled nursing facility, but who, because of their mental or physical condition, require institutional care and services, above the level of room and board. Id. § 1396d(c).

providers, and, as mandated by federal law, each amicus state has established administrative appeal procedures whereby each institutional provider may obtain review of its reimbursement rate.3/ Each amicus has a vital interest in the outcome of this case. The core question

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3/ These administrative appeal procedures are set forth, for example, at Alaska Stat. § 47.07.075 (1984); Cal. Welf. & Inst. Code § 14087.27 (1987); Haw. Admin. R. § 17-748 (1985); Idaho Code §§ 56-132 (1986); Kan. Stat. Ann. § 75-3306 (1984); Me. Med. Assis. Manual § 1.18 (1979); Miss. Code Ann. § 43-13-121(i)(a)(iv) (Supp. 1985); Mo. Rev. Stat. §§ 208.156, 621.055 (1983); Nev. Medicaid Services Manual § 506 (1987); N.J. Court Rules § 2:2-3(2) (1987); N.C. Admin. Proc. Act, arts. 3 & 4, ch. 150B (1986); N.D. Admin. Code § 75-02-06-16(7) (1986); Ohio Rev. Code Ann. § 5111.06 (1981); Utah Code Ann. § 26-23-2 (1984); Va. Code § 9-6.14:1 (1985); Vt. Stat. Ann. tit. 33, § 195 (1978); Wash. Rev. Code § 74.46.770 (1987); and Wis. Stat. § 227.42 (1985-86).

in this case is whether, as the Court of Appeals held, a complaint about the adequacy of the Medicaid reimbursement rate that a state has established for a particular institutional provider entitles the provider to sue the state in federal court under 42 U.S.C. § 1983.4/ Each amicus is interested in the resolution of this issue because, like Oregon, each would potentially be subject to thousands

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4/ 42 U.S.C. § 1983 (1982) provides in pertinent part:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . .."

of suits each year in federal court if the broad holding of the Court of Appeals is sustained. This substantial interest warrants the submission of this brief in support of Oregon's effort to obtain reversal of the Court of Appeals' decision below.

LEGAL AND PROCEDURAL BACKGROUND

Respondents' complaint alleged as a cause of action that Oregon had violated the requirements of 42 U.S.C. § 1396a(a)(13)(A).[5/] See Appendix E to Petitioners'

5/ Section 1396a(a)(13)(A) requires each state participating in the Medicaid program to provide in its State Plan for the reimbursement of providers of institutional care

> "through the use of rates (determined in accordance with methods and standards developed by the States and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low

(Footnote Continued)

Petition for Certiorari (P. Pet. Cert. App. E), ¶¶ 15, 31.

While respondents' complaint recites a number of factual allegations, the Court of Appeals cited, and its holding was premised upon, only one: that, in establishing the reimbursement rate

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(Footnote Continued)

> income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary [of Health and Human Services], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with the applicable State and Federal laws, regulations and quality and safety standards . . .."

Respondents also claimed that Oregon's conduct constituted a breach of contract, a deprivation of constitutional rights, and a violation of state law and federal Medicaid regulations. P. Pet. Cert. App. E, ¶¶ 31, 34, 37. The Court below did not reach the issue of whether section 1983 afforded respondents a remedy for those alleged violations.

for respondent Coos Bay Care Center, Oregon "withheld certain 'heavy care' Medicaid payments and reimbursements."[6/] 803 F.2d at 1061. For Oregon's alleged violation of section 1396a (a)(13)(A) in failing to reimburse respondent Coos Bay's heavy-care costs, respondents sought a remedy under 42 U.S.C. § 1983.

6/ Respondents alleged that applicable state regulations provided for complete reimbursement for the costs of providing heavy care. P. Pet. Cert. App. E ¶ 17. Respondents' complaint also alleged that Oregon had developed a policy of refusing to pay the costs of heavy care to respondent Coos Bay Care Center as well as to other long-term health care facilities providing care to heavy-care patients. Id., ¶¶ 23, 24. In addition, respondents' affiant alleged that Oregon had failed to make available to respondent Coos Bay Center an administrative procedure whereby it could obtain review of its rate. Respondents' Brief in Opposition to Certiorari, p. 19. The Court of Appeals did not premise its holding on the existence of these allegations and, in fact, did not even acknowledge these allegations.

The District Court, adopting a magistrate's findings and recommendations, dismissed respondents' action for failure to state a claim and lack of jurisdiction. P. Pet. Cert. App. B. The magistrate, relying on this Court's decision in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981), had concluded, inter alia, that the Medicaid statute and regulations create no substantive, enforceable rights or private right of action. P. Pet. Cert. App. C, pp. 12-13.

The Court of Appeals reversed the decision of the District Court and remanded the action for trial. The Court of Appeals found that this Court's decision in Maine v. Thiboutot, 448 U.S. 1 (1980) (section 1983 affords a remedy for violation of provisions of the Social Security Act), obviated the need for

lengthy analysis and required a finding that respondents' complaint alleging violations of section 1396a(a)(13)(A) was entitled to consideration on the merits under section 1983. 803 F.2d at 1062. Further, while acknowledging that the Medicaid statute "permits" states to establish "complementary" administrative review procedures for disputes over Medicaid reimbursement, the Court of Appeals found no indication in the statute of a congressional intent to foreclose enforcement of the statute's provisions under section 1983. Id. The court also found no bar to an action by Medicaid patients and their health care providers to enforce section 1396a(a)(13)(A). Id. The court held that "statutory rights under Title XIX of the Social Security Act [had] been alleged in the complaint

which are sufficient to state a claim under 42 U.S.C. § 1983." Id. at 1063.

SUMMARY OF ARGUMENT

Amici respectfully submit that the Court of Appeals' broad holding -- that an institutional Medicaid provider and its patients may bring suit under section 1983 to challenge the adequacy of the provider's particular Medicaid reimbursement rate[7/] -- must be reversed.

7/ The Court of Appeals' decision necessarily is premised on the holding that section 1983 affords a federal forum to challenge a particular provider rate because the court gave no indication that its decision was dependent on the existence in respondents' complaint of the allegation that Oregon had a general policy of refusal to reimburse heavy-care costs, or on the allegation that Oregon had effectively denied heavy-care providers the opportunity to have meaningful administrative review of their rates. Indeed, as earlier noted, the court made no reference to such allegations. Amici believe that the Court need not decide

(Footnote Continued)

The effect of the court's decision is improperly to permit any institutional provider to sue under section 1983 to challenge its Medicaid reimbursement rate, even though the Medicaid statute imposes no requirement that a state make assurances about the rate established for each individual provider. The decision below should also be reversed because, in permitting a provider to challenge its reimbursement rate in federal court without regard to whether the provider has sought state administrative review of the rate, the decision frustrates the congressional intent that the

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(Footnote Continued)
here whether such allegations state a claim cognizable under section 1983. As amici explain below, to the extent that the holding below permits a section 1983 suit to be maintained to challenge a particular provider rate, it is overly broad and should not be permitted to stand.

states have broad latitude to implement their Medicaid reimbursement plans.

The Court of Appeals' holding that a provider may sue under section 1983 to challenge its reimbursement rate is also erroneous because federal law, which mandates that the states provide administrative appeal procedures whereby institutional Medicaid providers may obtain review of their rates, establishes a comprehensive remedial scheme that should preclude a remedy under section 1983.[8/] The effects of leaving the

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8/ Amici do not discuss in detail this point (which follows from this Court's decision in Middlesex County Sewerage Authority v. National Sea Clammers Ass'n, 453 U.S. 1, 19-21 (1980)) so as not to burden the Court with repetition of an argument ably presented by the petitioner in its brief. For the same reason amici do not repeat, but fully endorse, the argument, presented in Oregon's brief in support of its

(Footnote Continued)

holding below to stand will be to disrupt, if not to thwart completely, the states' carefully-tailored rate review procedures and to impose a severe burden on state resources and federal court dockets.

ARGUMENT

THE COURT OF APPEALS' HOLDING THAT SECTION 1983 AFFORDS AN INSTITUTIONAL MEDICAID PROVIDER A REMEDY TO CHALLENGE ITS PARTICULAR REIMBURSEMENT RATE IS ERRONEOUS, FRUSTRATES THE OBJECTIVES UNDERLYING SECTION 1396a(a)(13)(A), AND DISRUPTS THE REMEDIAL SCHEME MANDATED BY CONGRESS.

(Footnote Continued)
petition for certiorari, that a violation of state Medicaid regulations does not amount to a violation of federal statutory rights that is cognizable under section 1983. As Oregon argues, and as supported by the reasoning of the court in Oberlander v. Perales, 740 F.2d 116 (2d. Cir. 1984), section 1983 should not be deemed to provide a federal forum for respondents' complaint that Oregon failed to provide an element of reimbursement to which respondent Coos Bay claims entitlement under state administrative regulations.

A. The Holding Below Rests on the Erroneous Assumption that Section 1396a(a)(13)(A) Imposes Requirements with Respect to the Particular Rates Established for Individual Medicaid Providers.

Section 1983 provides a remedy that "encompasses violations of federal statutory . . . law." Maine v. Thiboutot, 448 U.S. 1, 4 (1980). The corollary of that rule, as this Court has recognized, is that a section 1983 remedy is not available where no violation of the terms of a federal statute is alleged, and where the relevant statute imposes on a state no obligation to do what it has allegedly failed to do. See Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 28-29 (1980). The fundamental error in the decision of the Court of Appeals lies in the court's failure to apply the rule recognized in Thiboutot and Pennhurst. The court erred in finding

a section 1983 remedy to be available even though the respondents' allegations as characterized by the court do not state a violation of section 1396a(a)(13)(A).

Respondents' sole claim acknowledged by the Court of Appeals was the claim that Oregon violated the requirements of section 1396a(a)(13)(A) by establishing a reimbursement rate for respondent Coos Bay Care Center that excluded reimbursement for certain heavy-care costs. However, as has been recognized by the Department of Health and Human Services ("DHHS" or "the Agency"), the federal agency responsible for implementing the Medicaid statute, section 1396a(a)(13)(A) does not require a state to ensure that the specific rate established by the state for each particular provider satisfies the reimbursement standard set forth in the section.

Rather, section 1396a(a)(13)(A) requires only that a state provide for payment to institutional providers at rates about which the state has made findings, and that the state assure the Agency that it has made the requisite findings.

In the preamble to its final regulations implementing section 1396a(a)(13)(A), the Agency described in great detail its understanding of what the section requires. See 48 Fed. Reg. 56046-56059 (1983). The Agency explained that its approval of a State's reimbursement plan, which "indicates that the State has complied with the requirements in [section 1396a(a)(13)(A)] and regulations," is based on the Agency's evaluation of the state's assurances "to determine whether the state has made a finding to substantiate that the payment rates are reasonable and adequate. . .." Id. at 56052. Significantly, the Agency

preamble indicates that, in order to assure the Agency that it has made the requisite findings, a state need not justify nor make any representations about the rates paid to individual providers. Id. at 56050.

The Agency explicitly rejected suggestions, submitted during the comment period, that the Agency's implementing regulations require the states to identify "providers not receiving full costs, and [to provide] an explanation of why providers not receiving full costs are not considered efficiently and economically operated." Id. Instead, "[i]n response to the concern regarding a State explanation as to why a provider is not considered an efficiently and economically operated facility," the Agency determined to require each state to "provide an appeal procedure to address the expressed

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concern of those individual facilities who believe they are efficient and economical but are being adversely affected by the State's payment rates." Id.

In sum, the Agency charged with implementing the Medicaid statute has interpreted section 1396a(a)(13)(A) not to require that a state make assurances about the rates it pays to particular institutional providers. That interpretation is consistent with the congressional intent that section 1396a(a)(13)(A) make participation in the Medicaid program less administratively burdensome for the states, and afford them greater flexibility in designing reimbursement methodologies than they had enjoyed previously. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 293

(1981).[9] The Agency's interpretation that section 1396a(a)(13)(A) does not impose requirements with respect to individual provider rates is a reasonable one,[10] to which this Court should defer.

9/ The Agency's understanding that section 1396a(a)(13)(A) was intended to result in the Medicaid program being less administratively burdensome for the states was also the basis of the Agency's determination not to require that the Medicare upper limit rule (i.e., the requirement that payment rates for institutional providers not exceed the rates that would have been payable under the Medicare program) be applied on a facility-specific basis. 48 Fed. Reg. 56055. The Agency's "regulations allow a State to use an aggregate vs. facility-specific application of the limit . . . in keeping with the congressional intent that the calculation of the limit not be an administrative burden on States." Id. at 56054.

10/ Indeed, it would hardly have been reasonable for the Agency to interpret section 1396a(a)(13)(A) to require states to make guarantees about the sufficiency of individual provider rates.

(Footnote Continued)

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837, 844 (1984); Red Lion Broadcasting Co. v. Federal Communications Commission, 395 U.S. 367, 381 (1969) (great deference should be accorded the construction of a statute by the agency required to execute it).

Amici are aware of only one federal court decision that has addressed the issue of whether the adequacy of the particular rate paid to an individual provider implicates a state's compliance with the requirements of section 1396a(a)(13)(A).11/ In that decision,

(Footnote Continued)
The states lack detailed knowledge about individual providers' financial and operational aspects, and are unable to predict future circumstances that may affect individual provider costs.

11/ Amici note that the recent decision in Bethany Medical Center v. Harder,
(Footnote Continued)

the court expressly held that the requirements of the section may be fully satisfied even though the general rates that a

(Footnote Continued)
No. 85-2415, slip op. (D. Kan. March 12, 1987) permitted a provider to sue under section 1983 for a state's alleged violation of section 1396a(a)(13)(A) in failing to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. The court's holding that the plaintiff had stated a claim for a violation of section 1396a(a)(13)(A) was based on plaintiff's amendment of its complaint to allege that the state's assurances that no hospital in the state was a disproportionate share provider had not been based on factual analysis or objective evidence. The case did not hold that the provider was entitled to sue under section 1983 on a mere claim that its individual rate was inadequate in not recognizing its particular costs.

A number of federal courts have entertained suits by providers or provider groups (more commonly the latter) complaining that states had adopted reimbursement methodologies without objective evidence or factual analysis that could support the findings and assurances and the Agency approval required under federal law (a claim that respondents here do not make). The Ninth Circuit Court of Appeals failed to recognize that it was such a complaint,
(Footnote Continued)

a state has established may be inadequate in the case of a particular provider. See, Mary Washington Hospital v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985). In

(Footnote Continued)
(i.e., a complaint about a state reimbursement plan) that was involved in every case cited by the court in support of its decision permitting a suit under section 1983 to challenge a particular provider rate. See 803 F.2d at 1063. (Moreover, none of the cases cited by the court involved section 1396a(a)(13)(A)). The court cited no case in which a federal court has permitted a suit by an institutional provider challenging the adequacy of its particular reimbursement rate.

By contrast, a number of federal courts (reasoning that providers are not the intended beneficiaries of the Medicaid statute) have held that Medicaid providers have no property interest in Medicaid reimbursement entitling them to challenge their individual reimbursement rates in federal court. See, e.g., Oberlander v. Perales, 740 F.2d 116 (2d Cir. 1984); Al-Charles Inc. v. Heintz, 620 F. Supp. 327 (D. Conn. 1985).

Mary Washington, the court, after describing in detail the process by which Virginia had made findings to support its rate-setting methodology,[12] rejected

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12/ The Mary Washington court's analysis implicitly recognized that the obligation imposed by section 1396a(a)(13)(A) is that each participating state make payment to providers through the use of rates about which the state has made findings and can make satisfactory assurances. The court's implicit holding was that section 1396a(a)(13)(A) is violated only when a state has adopted a rate-setting mechanism without having made reasoned findings or has failed to provide the required assurances.

As this Court reasoned in the context of considering a statutory provision imposing analogous "assurance" requirements, "[i]t is at least an open question whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 28 (1980). Careful analysis of section 1396a(a)(13)(A) not only compels the conclusion that the inadequacy of particular provider rates

(Footnote Continued)

a provider's claim that Virginia had violated the requirements of section 1396a(a)(13)(A) in setting reimbursement rates for inpatient hospital services. The court observed:

> "while the court has determined that the general rates Virginia has set for hospital reimbursement are not in conflict with the governing federal law, this conclusion does not mean, however, that those general rates will be adequate in every case. For a variety of reasons, reasonable general rates may not be reasonable and adequate in particular cases to assure reasonable access and to cover the costs of efficiently and economically operating hospitals. This may be due to some fact about a hospital or group of hospitals that the state did not take into account in setting the general rate . . . . Whatever the reason, the appropriate way to deal with this problem . . . is through some form of appeals or

(Footnote Continued)
cannot form the basis of a challenge under section 1983, but also raises the similar issue -- an issue that the Court need not decide here -- of whether a properly alleged violation of section 1396a(a)(13)(A) could ever give rise to a remedy under section 1983.

> exception process." (Emphasis in the original.)

Id. at 903. The Mary Washington court's analysis recognized that the requirements of section 1396a(a)(13)(A) cannot be said to be violated simply because a particular provider's rate is inadequate.

By contrast, the Ninth Circuit Court of Appeals failed even to address the issue of whether a claim that a particular provider rate fails to satisfy the reimbursement standard set forth in section 1396a(a)(13)(A) states a violation of the requirements of the section.13/ The

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13/ The Court of Appeals did reason that it is "actions which properly allege violations of 42 U.S.C. § 1396a(a)(13)(A)" that are entitled to consideration on the merits under section 1983, 803 F.2d at 1061, but failed to address the issue of whether respondents had alleged any conduct or omission that could be deemed a violation of section 1396a(a)(13)(A).

effect of the court's decision, however, is t. permit any provider making such a claim to sue under section 1983. This Court should reverse the Court of Appeals' decision, on the grounds that an allegation that an individual provider's rate is inadequate does not state a violation of section 1396a(a)(13)(A) and, for that reason,[14/] does not give rise to a remedy under section 1983.

14/ The Court need not even reach the question of whether this case falls under one or both of the exceptions to the availability of a section 1983 remedy established by this Court's decisions in Pennhurst and Middlesex County and summarized in Wright v. City of Roanoke Redevelopment & Housing Authority, 107 S. Ct. 766, 770 (1987) (exception to the application of section 1983 to remedy statutory violations exists where Congress foreclosed such enforcement in the statute and where the statute did not create enforceable rights). The threshold question is not whether section 1396a(a)(13)(A) creates any rights enforceable under

(Footnote Continued)

B. The Holding Below Conflicts with the Statutory Objective of Affording the States Broad Latitude in Developing and Implementing Medicaid Reimbursement Methodologies

An additional reason warranting reversal of the decision below is that its effect is to undermine the states' ability to implement the administrative review procedures they have established,

(Footnote Continued)
section 1983, but whether a claim to a particular level of reimbursement for an individual provider comes within the scope of the right (if any) that Congress intended to confer. Cf. Wright v. City of Roanoke Redevelopment and Housing Authority, 107 S. Ct. at 776 (1983) (O'Connor, J., dissenting) (assuming that federal housing statute conferred on tenants rights to enforce provision requiring reasonable rent, question remained whether tenants' claim to reasonable utilities came within scope of right Congress intended to confer); Bumpers v. Clark, 681 F.2d 679, 684 (9th Cir. 1982) (even if provision of Medicaid statute conferred some substantive rights against the states, it did not create the rights claimed by plaintiffs).

and thus their ability to implement fully their reimbursement methodologies.

The point that amici urge the Court to recognize differs in a perhaps subtle, but significant way from an argument that the holding below permits court action before administrative remedies have been exhausted.15/ The point amici make is more basic: each state's administrative rate review procedure is an essential element of its reimbursement system.16/ Accordingly, a judicial

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15/ Thus, the Court need not consider whether this case presents an exception to the rule, established by the cases discussed in Patsy v. Board of Regents, 457 U.S. 496, 507-512 (1986), that exhaustion of state administrative remedies is not a prerequisite to an action under section 1983.

16/ See 48 Fed. Reg. 56056 (1983). In adopting final rules to implement section 1396a(a)(13)(A), DHHS indicated that it was deleting its regulation

(Footnote Continued)

holding that permits a provider to challenge its reimbursement rate under section 1983 without first having resorted

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(Footnote Continued)
requiring state appeals procedures as a separate requirement and instead was placing that requirement in its regulations establishing the general requirements of state reimbursement plans in order to "consolidat[e] the essential elements of a State's reimbursement system to a single section of the regulations," and to make the appeals process the subject of assurances. Id. at 56047, 56056.

Moreover, the federal agency in practice treats the states' appeals procedures as an essential element of their reimbursement plans. Before approving a state's payment methods and standards, the Agency "evaluates [the state's] assurances to determine . . . that appropriate appeals procedures in compliance with the [Agency] regulations are in effect." Id. at 56052.

In addition, it is noteworthy that the states typically describe their administrative rate review procedures in Attachments 4.19-A and 4.19-D of their State Plans, wherein they are required to specify comprehensively their methods and standards of payment for hospitals and long-term-care facilities.

to state administrative rate review procedures requires a state to defend in federal court the rates it has established before the state has had an opportunity to finish applying its rate-setting process by implementing an essential element of that process.

The foregoing is precisely the result of the Ninth Circuit's holding. As a result, the court's decision undermines the congressional intent behind section 1396a(a)(13)(A), that states be afforded broad freedom to develop and implement their reimbursement methodologies. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981); Charleston Memorial Hospital v. Conrad, 693 F.2d 324, 331 (4th Cir. 1982). A judicial holding which so frustrates the statutory intent should not be sustained.

C. The Effect of the Decision Below Will Be to Pre-Empt the Congressionally-Mandated State Rate Review Procedures and to Overburden the Federal Court Dockets

Agency regulations at 42 C.F.R. § 447.253(c) require each state Medicaid agency to provide an appeals or exception procedure that allows individual institutional providers an opportunity to submit additional evidence and receive prompt administrative review of their payment rates.17/ In promulgating section 447.253(c), the Agency declined to provide greater specificity in its appeals regulation, recognizing that the states "are in the best position to determine the administrative process that

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17/ The Court of Appeals erroneously observed that Title XIX merely "permits states to establish administrative review procedures for disputes over Medicaid reimbursements" (emphasis added). 803 F.2d at 1062.

would best meet their needs and be most compatible with their reimbursement system." 48 Fed. Reg. 56052.

The amici states have employed the flexibility afforded them under federal regulations, and have invested considerable time and expense in developing administrative review procedures and guidelines carefully tailored to their reimbursement plans. At substantial cost to the states, state administrative officers have developed considerable expertise in applying complex rate formulae, and considerable expertise about local health care industry conditions, provider inflation experience and other relevant factors within their states. State administrative adjudicatory bodies have developed bodies of administrative law on which providers can rely in making rate appeals and to which the states

can refer in resolving rate disputes. Moreover, virtually all of the amici states afford institutional Medicaid providers the right to appeal administrative rate-review decisions to their state courts.18/

18/ See Ariz. Rev. Stat. Ann. § 36-2932H (1987); Cal. Civ. Proc. Code § 1094.5 (1981); Ga. Code Ann. §49-4-153 (Supp. 1987); Haw. Rev. Stat. § 9114 (1983); Idaho Code § 67-5215 (1980 & Supp. 1987); Ind. Code § 4-21.5-5-1 (1986); Kan. Stat. Ann. § 77-601 (1986); La. Rev. Stat. Ann. § 49:964 (1967); Me. Med. Assist. Man. § 1.18 (1979); Mass. Gen. Laws Ann. chs. 6A, § 36, and 30A, ¶ 14 (1976); Mich. Comp. Laws § 400.111f (Supp. 1987); Minn. Stat. § 14.63 (1986); Mo. Rev. Stat. § 621.145 (1986); Mont. Admin. R. § 46.2.212 (1979); Neb. Rev. Stat. § 84-917 (1983); N.Y. Civ. Prac. Law § 78; N.C. Gen. Stat. §§ 150B-43; N.D. Cent. Code § 28-32-15 (1986); Ohio Rev. Code Ann. § 119.12; Utah Code Ann. § 26-23-2 (Supp. 1987); Vt. Stat. Ann. tit. 3, § 815 (1985); Va. Code § 32.1-325.1 (1986); Wash. Rev. Code § 34.04.130 (1985); § 227.53 Wis. Stat. (1985-86).

The effect of the decision below by the Ninth Circuit Court of Appeals will be to disrupt the states' thoughtfully developed and carefully-tailored review procedures by permitting them to be by-passed by providers who prefer to have their day in federal court, and similarly to disrupt developed bodies of administrative law by laying the ground for disparate state and federal decisions. Moreover, in light of the fact that the states annually review thousands of rate appeals, it can realistically be expected that, if the court's decision stands, thousands of new plaintiffs would flood the federal courts with rate disputes -- disputes which the courts, lacking a grounding in the states' highly technical rate-setting mechanisms, are ill-prepared to resolve. That is a result that offends the goals of judicial economy and efficient

use of federal court resources, and for which their is no justifying policy rationale. Nor is there a need for the Court to stretch to find a section 1983 remedy.19/ The states amply provide rate-review remedies, as befits each state in its role of carrying out what is essentially a state medical assistance program.

Thus, policy considerations, too, warrant a judgment by this Court reversing the Court of Appeals' ill-reasoned decision.

19/ Cf. Block v. Community Nutrition Institute, 348 U.S. 340, 348, 352 (1984) (suit of type that could severely disrupt administrative scheme could be precluded since preclusion would not threaten realization of fundamental objectives of statute).

CONCLUSION

For all the foregoing reasons, as well as for the reasons cited in petitioners' briefs, amici urge the Court to reverse the decision below.

Respectfully submitted,

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No. 86-1419

IN THE
SUPREME COURT OF THE UNITED STATES

October Term 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

AFFIDAVIT OF SERVICE

At the request of the First Deputy Attorney General of Hawaii, the counsel of record, I have served the "Brief of the States of Arizona (through the Arizona Health Care Cost Containment System), Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands as Amici Curiae in Support

of Petitioners" this 25th day of July, 1987, by causing copies thereof to be mailed first-class, postage prepaid to counsel for respondents Donald W. Lojek, Esq. and Bradley H. Hall, Esq., 711-1/2 West Bannock, Boise, Idaho 83701, and Robert J. Saalfeld, Esq., P.O. Box 470, Salem, Oregon 97308. I have also caused copies to be mailed postage prepaid, to Philip Schradle, Assistant Attorney General, Department of Justice, Appellate Division, Justice Building, Salem, Oregon 97310.

On the basis of the foregoing, I hereby certify that all parties required to be served by Rule 28 of the Rules of this Court have been served.

Phyllis D. Thompson

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Subscribed and sworn before me this 25th day of July, 1987.

Notary Public

My Commission Expires: My Commission Expires November 14, 1990.